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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

6916

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

09170

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hosp.</u>				STREET ADDRESS (If rural give location) <u>606A Western Circle</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Baby Boy</u> <u>Gimes</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>9-19</u> <u>1955</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>col.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>none</u>	<b>8. DATE OF BIRTH</b> <u>9-19-55</u>	<b>9. AGE last birthday</b> <u>4</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>none</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Wid. A Virginia Ames</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Wid. A Virginia Ames</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>762.0</u> IMMEDIATE CAUSE (A) <u>atelectasis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>1</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>9/19</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <u>9-19-55</u> <u>5:35</u> M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>9/19/55</u> , <b>to</b> <u>9/19</u> , <b>19</b> <u>55</u> , <b>that I last saw the deceased alive on</b> <u>9/19</u> , <b>19</b> <u>55</u> , <b>and that death occurred at</b> <u>5:35</u> <b>A.M.</b> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>William C. Morgan</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Salisbury, Md</u>			
<b>DATE SIGNED</b> <u>9/21/55</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>cremation</u>		<b>DATE THEREOF</b> <u>9-21-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Peninsula General Hospital</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Salisbury, Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>9-21-55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary W. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Peninsula General Hospital</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF DEATH: *September 23, 1955*

5. PLACE OF DEATH: *Home*

6. CAUSE OF DEATH: *Heart Disease*

7. SIGNATURE OF PHYSICIAN: *[Signature]*

8. SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. 2

SEP 23 1955

RECEIVED

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1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

09171

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Worcester</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <b>Salisbury</b>		2 yrs		TOWN <b>Snow Hill</b> 23X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Deer's Head State Hospital</b>				STREET ADDRESS (If rural give location) <b>Dighton Avenue</b> ✓			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>Fred Anthony</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>9 12 19 55</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10/30/1887</b>		9. AGE last birthday <b>67</b> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Anthony</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Unk.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Hospital records</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				4 days			
022X IMMEDIATE CAUSE (A) <b>Ruptured aneurysm of left subclavian artery</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>Syphilis</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9/30/19 53</b> , to <b>9/12 19 55</b> , that I last saw the deceased alive on <b>9-12 19 55</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>R. J. Gore</b>		R. J. Gore, M.D. M.D.		ADDRESS (Street, city, town, or county) <b>Deer's Head Hospital Salisbury, Maryland</b>		DATE SIGNED <b>md</b>	
23. BURIAL, CREMATION REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Sept. 14/55</b>		NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery</b>		LOCATION (City, town, or county) (State) <b>Snow Hill md</b>	
24. REC'D-BY REGISTRAR <b>SEP 14 1955</b>		REGISTRAR'S SIGNATURE <b>Mary H. Zallaway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Walter E. Dummer</b>		ADDRESS <b>Snow Hill, md</b>	

# CERTIFICATE OF DEATH

BUREAU V. 1

SEP 15 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09172

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snow Hill</u> 23X-2 STREET ADDRESS <u>RT. # 2</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Ayres</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>September 14--19 55</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>none</u>	8. DATE OF BIRTH <u>September 14 1955</u>	9. AGE last birthday yrs. Months Days <u>6</u> <u>10</u> <u>9</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Benjamin Franklin Ayres</u>			14. MOTHER'S MAIDEN NAME <u>Ella Cordelia Milbourne</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 762.5 IMMEDIATE CAUSE (A) <u>anoxia</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH		
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>9/14</u> , 19 <u>55</u> , to <u>9/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/14</u> , 19 <u>55</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.		ADDRESS (Street, city, town, state) <u>Salisbury, Md</u>		DATE SIGNED <u>9/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>9/16/55 Peninsula General Hospital Salisbury, Md</u>		24. REC'D BY REGISTRAR DATE <u>9-16-55</u> REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>					
25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS					

3795252260



CERTIFICATE OF DEATH

00133

SEP 19 1955

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF NOTARY

20. SIGNATURE OF OTHER OFFICIAL

21. SIGNATURE OF OTHER OFFICIAL

22. SIGNATURE OF OTHER OFFICIAL

23. SIGNATURE OF OTHER OFFICIAL

24. SIGNATURE OF OTHER OFFICIAL

25. SIGNATURE OF OTHER OFFICIAL

26. SIGNATURE OF OTHER OFFICIAL

27. SIGNATURE OF OTHER OFFICIAL

28. SIGNATURE OF OTHER OFFICIAL

29. SIGNATURE OF OTHER OFFICIAL

30. SIGNATURE OF OTHER OFFICIAL

31. SIGNATURE OF OTHER OFFICIAL

32. SIGNATURE OF OTHER OFFICIAL

33. SIGNATURE OF OTHER OFFICIAL

34. SIGNATURE OF OTHER OFFICIAL

35. SIGNATURE OF OTHER OFFICIAL

36. SIGNATURE OF OTHER OFFICIAL

37. SIGNATURE OF OTHER OFFICIAL

38. SIGNATURE OF OTHER OFFICIAL

39. SIGNATURE OF OTHER OFFICIAL

40. SIGNATURE OF OTHER OFFICIAL

41. SIGNATURE OF OTHER OFFICIAL

42. SIGNATURE OF OTHER OFFICIAL

43. SIGNATURE OF OTHER OFFICIAL

BUREAU V. S.

SEP 19 1955

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9205

## CERTIFICATE OF DEATH

09173

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Delmar</b>		<b>50 yrs</b>		OR TOWN <b>Delmar</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>6 W. State Street</b>				<b>6 W. State Street</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>William</b> (Middle) <b>Joseph</b> (Last) <b>Benson</b>				(Month) <b>Sept.</b> (Day) <b>5</b> (Year) <b>55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>Oct. 19, 1869</b>	<b>85</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Retired Janitor</b>		<b>School</b>		<b>Sussex County, Del.</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>John Benson</b>				<b>Jane Elliott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>		<b>None</b>		<b>Ida Benson, Delmar, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <b>Coronary Thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Coronary Thrombosis</b>						<b>6 hours</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Ischemic Heart Disease</b>						<b>5 weeks</b>	
						<b>10 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<b>0</b>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 31, 1954</b> to <b>Aug 5, 1955</b> that I last saw the deceased alive on <b>Aug 4, 1955</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.							
SIGNATURE <b>A. H. Lynch</b>				M.D.		DATE SIGNED <b>Aug 7 - 55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<b>Burial</b>		<b>9-7-55</b>		<b>Mt Olive</b>		<b>Delmar, Del.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>Sept. 8, 1955</b>		<b>Mary H. Holloway</b>		<b>W. S. Spaulding</b>		<b>Delmar, Del.</b>	

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BUREAU V. S.

SEP 8 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9162

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09174 Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>12 TOWN Salisbury</b>		LENGTH OF STAY (in this place) <b>All life</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>At home - 503 W. Isabella St.</b>				STREET ADDRESS (If rural, give location) <b>503 W. Isabella Street</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <b>Frederick Douglass Black</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>9- 17- 1955</b>				
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Infant</b>	8. DATE OF BIRTH: <b>8-27-55</b>		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min. <b>20</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Baby</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Baby</b>		11. BIRTHPLACE (State or foreign country): <b>Salisbury, Wicomico Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Baby</b>	
13. FATHER'S NAME: <b>Donald Purnell</b>				14. MOTHER'S MAIDEN NAME: <b>Beverly L. Black</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>Baby</b>		(If Yes, give war or dates of service) <b>Baby</b>		16. SOCIAL SECURITY No.: <b>Baby</b>		17. INFORMANT & ADDRESS: <b>Salisbury, Md. Beverly L. Black, 503 W. Isabella Street</b>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							Sudden
<b>500X</b> Immediate cause (a)..... <b>Acute tracheo-bronchitis.</b> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <b>22</b>		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>Emil L. Royce</b>		M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>9-20-55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>9-20-55</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		LOCATION (City, town, or county) (State) <b>Fruitland, Wicomico Co., Md.</b>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>		24. FUNERAL DIRECTOR <b>Mary A. Stewart</b>		ADDRESS <b>324 E. Church Salisbury, Md.</b>	

285161405

93121

Wisconsin

Wisconsin

Wisconsin

Salisbury

All life

Salisbury

100 W. Lincoln Street

At home - 100 W. Lincoln St.

Salisbury

20

2-27-55

Body

Salisbury, Wisconsin Co. W.

Body

Body

Reverly I. Black

Reverly I. Black

Salisbury, Md.

Reverly I. Black, 100 W. Lincoln Street

Body

Body

Body

BUREAU V. E.

SEP 23 1955

RECEIVED

St. Albans Cemetery

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09175

9206

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Pittsville</u>		LENGTH OF STAY (in this place) <u>4 Yrs.</u>		TOWN <u>Pittsville</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pittsville</u>				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>MERRITT</u> (First) <u>GOODRICH</u> (Middle) <u>CHAMBERS</u> (Last)				<u>9</u> <u>10</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 30, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Doctor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William G. Chambers</u>				14. MOTHER'S MAIDEN NAME <u>Martha Hackett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Helen H. Chambers, Same</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____				DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION _____		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>9-1</u> , 19 <u>53</u> , to <u>9-10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-10</u> , 19 <u>55</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Paul M. Bondsley</u>				ADDRESS (Street, city, town, state) <u>909 E. Church Salisbury Md</u> DATE SIGNED <u>9-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>9/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Wm J. Lee Crematory</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR <u>SEP 14 1955</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u> ADDRESS <u>The Hill &amp; Johnson Co. Salisbury, Md.</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Form No. 100

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. DATE OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CORONER

15. SIGNATURE OF DECEASED

16. SIGNATURE OF REGISTRAR

BUREAU V. 2

SEP 14 1955

RECEIVED

The H.M. & Johnson Co.

RECEIVED

This is a certificate of death issued by the Maryland State Department of Health, Baltimore, Maryland, on the 14th day of September, 1955, at the residence of the deceased, 1234 Main Street, Baltimore, Maryland. The deceased was a white male, born on the 1st day of January, 1910, at Baltimore, Maryland. He was a resident of Baltimore, Maryland, for the last five years of his life. He was employed as a clerk in the Baltimore City Office of the Maryland State Department of Health. He died of a heart attack, which was caused by atherosclerosis of the coronary arteries. The death was sudden and unexpected. The body was found by the police on the 14th day of September, 1955, at the residence of the deceased. The body was taken to the Baltimore City Morgue for examination. The examination was conducted by the Baltimore City Coroner, who issued a certificate of death. The body was buried in the Baltimore City Cemetery on the 15th day of September, 1955. The burial was conducted by the Baltimore City Board of Health. The certificate of death is valid for all purposes. It is a true and correct copy of the original certificate of death. The original certificate of death is on file in the Baltimore City Office of the Maryland State Department of Health. The copy of the certificate of death is being furnished to the family of the deceased. The family of the deceased is requested to keep this copy of the certificate of death in a safe place. The certificate of death is a legal document. It is a true and correct copy of the original certificate of death. The original certificate of death is on file in the Baltimore City Office of the Maryland State Department of Health. The copy of the certificate of death is being furnished to the family of the deceased. The family of the deceased is requested to keep this copy of the certificate of death in a safe place. The certificate of death is a legal document. It is a true and correct copy of the original certificate of death. The original certificate of death is on file in the Baltimore City Office of the Maryland State Department of Health. The copy of the certificate of death is being furnished to the family of the deceased. The family of the deceased is requested to keep this copy of the certificate of death in a safe place.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9163

## CERTIFICATE OF DEATH

09176

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>4½ months</u>		CITY OR TOWN <u>Tyaskin</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS <u>RFD # 1</u>		(If rural give location) <u>/</u>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>EZRA BARTLEY CHARLES</u>				<u>9 22 19 55</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Jan. 8, 1892</u>	<b>9. AGE last birthday</b> <u>63</u> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
				Months		Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>--</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Carolina</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						<u>5 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>11 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>May 3, 1955</u> , <b>to</b> <u>Sept. 22, 1955</u> , <b>that I last saw the deceased alive on</b> <u>Sept. 22, 1955</u> , <b>and that death occurred at</b> <u>9:10 AM</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>V. Juerman</u> <b>V. Juerman, M.D.</b>				<b>ADDRESS</b> (Street, city, town, state) <u>Deer's Head Hospital, Salisbury, Maryland</u>		<b>DATE SIGNED</b> <u>9/22/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Sept. 25, 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Gilford Memorial Park Cem.</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Gilford County N. Carolina</u>	
<b>24. RECEIVED BY REGISTRAR</b> <u>Sept. 26, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary K. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u> <b>ADDRESS</b> <u>SALISBURY MARYLAND</u>			





9164

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Selbyville</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA General Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
		OF DEATH <u>September 7 1955</u>					
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>September 6-55</u>	9. AGE last birthday <u>20</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Ralph Delmar Cobb</u>				14. MOTHER'S MAIDEN NAME: <u>Jeanette Bertha McGee</u>			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Fetal anoxemia with</u>		DUE TO <u>malnourishment of fetus</u>		<u>unknown</u>			
ANTECEDENT CAUSE (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u>		DUE TO <u>Kinking of cord</u>					
		(C) <u>Stillbirth of NB.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/6/55</u> , 19 <u>55</u> to <u>9/7/55</u> , 19 <u>55</u> that I last saw the deceased alive on <u>9/7</u> , 19 <u>55</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. W. Sunderwood</u>		ADDRESS <u>906 N. Division St. Salisbury</u>		DATE SIGNED <u>9/7/55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>9-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Ocean View Del.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		24. FUNERAL DIRECTOR <u>Wm Howard Wells</u>		ADDRESS <u>Pittsville</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 9 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9165

## CERTIFICATE OF DEATH

09178

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>1 Day</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>713 Roger St.,</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
<u>ROBERT McLEAN COLLINS</u>				<u>9 17 55</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Male</u>		<u>White</u>		<u>Widowed</u>		<u>Dec 17, 1889</u>	
<b>9. AGE last birthday</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>65 yrs.</u>		<u>Ret. House Painter</u>		<u>Maryland</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Charlie Collins</u>				<u>Anda Lewis</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>217-10-2141</u>		<u>Mrs Franklin Ennis, Same</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Acute Cardiac Decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis arteriosclerotic</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Sept. 4, 1954</u>, to <u>Sept. 17, 1955</u>, that I last saw the deceased alive on <u>Sept. 17, 1955</u>, and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Frederic A. Lowrey</u>				<u>116 E. Main St., Salisbury, Md. 9/19/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>9/19/55</u>		<u>St. John's Cemetery</u>		<u>Powellville, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>Sept. 20, 1955</u>		<u>Mary H. Holloway</u>		<u>The Hill &amp; Johnson Co. Salisbury, Md.</u>			
				<u>Norman T. Baker</u>			

Leigton General Hospital

rechnerisch zu prüfen.

enilic3 aifzud

BUREAU V. S.

SEP 20 1955

RECEIVED

John A. Connors

The Hill & Johnson Co., Baltimore, Md.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09179

9207

## CERTIFICATE OF DEATH

Item 9 FilmG186 9-20-55 et

Reg. Dist. No. 335

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>SHARPTOWN</u>		<u>72 YRS</u>		TOWN <u>SHARPTOWN</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WATER ST</u>				STREET ADDRESS (If rural give location) <u>WATER ST</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>JOSEPH PHILLIPS COOPER</u>				<u>SEPT 6 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>SEPT 25, 1876</u>	<u>79 YRS.</u>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>MERCHANT</u>		<u>GROCERY</u>		<u>MD</u>		<u>U.S.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>SAMUEL J. COOPER</u>				<u>RACHEL ANN PHILLIPS</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>NO</u>		<u>220-32-7592</u>		<u>MRS MARGARET COOPER</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1 IMMEDIATE CAUSE</b> (A) <u>Cerebral Embolism</u>						<u>2 Wks</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Hypertension - Coronary Thrombosis</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<u>0</u>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)			<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>		
<b>22. I hereby certify that I attended the deceased from</b> <u>July 31, 1955</u> , to <u>Sept 6, 1955</u> , that I last saw the deceased alive on <u>Sept 6, 1955</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Honor Elliott</u>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
				<u>M.D. Laurel - Del</u>		<u>9-9-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>BURIAL</u>		<u>SEPT 9-55</u>		<u>FIREMENS</u>		<u>SHARPTOWN MD</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>SEP 13 1955</u>		<u>Mary Cowen</u>		<u>Paul J. Smith, Sharptown, Md</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

1955

Form 100-10

1. Name of deceased (Print or type)

2. Date of death

3. Place of death

4. Cause of death

5. Name of physician (Print or type)

6. Name of hospital (Print or type)

7. Name of funeral home (Print or type)

8. Name of informant (Print or type)

9. Sex

10. Age

11. Race

12. Marital status

13. Occupation

14. Date of birth

15. Date of death

16. Date of death

17. Date of death

18. Date of death

19. Date of death

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50. Date of death

51. Date of death

52. Date of death

NOTED: This certificate is valid only if filed with the proper authorities.

1. Name of deceased (Print or type)  
2. Date of death  
3. Place of death  
4. Cause of death  
5. Name of physician (Print or type)  
6. Name of hospital (Print or type)  
7. Name of funeral home (Print or type)  
8. Name of informant (Print or type)  
9. Sex  
10. Age  
11. Race  
12. Marital status  
13. Occupation  
14. Date of birth  
15. Date of death  
16. Date of death  
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BUREAU V. S.

SEP 13 1955

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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9208

CERTIFICATE OF DEATH

09180

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>X</b> TOWN <b>Fruitland</b>		LENGTH OF STAY (in this place) <b>Most of life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Fruitland</b> <b>X</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>At home - Fruitland, Md.</b>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) <b>Cecile</b> (Middle) <b>Fountain</b> (Last) <b>Cottman</b>				4. DATE OF DEATH (Month) <b>9</b> (Day) <b>6</b> (Year) <b>19 55</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>A.A.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>5-25-1892</b>	9. AGE last birthday <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>11</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Polks Road, Somerset Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Paige</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Langford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Richard Cottman, Fruitland, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A) <b>Diabetic Acidosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>undetermined</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>diabetes mellitus</b>				<b>undetermined</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept. 1, 1955</b> , to <b>Sept. 6, 1955</b> , that I last saw the deceased alive on <b>Sept. 6, 1955</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>J. Hurnell</b>				ADDRESS (Street, city, town, state) <b>652 W. Main St., Salisbury Md.</b>			
DATE SIGNED <b>SEP 13 1955</b>				DATE SIGNED <b>SEP 15 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>9-10-55</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		LOCATION (City, town, or county) (State) <b>Fruitland, Wicomico Co. Md.</b>	
24. REC'D BY REGISTRAR <b>Mary H. Holloway</b>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <b>Mary A. Stewart</b>		ADDRESS <b>324 E. Church St. Salisbury, Maryland</b>	

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BUREAU V. S.

SEP 13 1955

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**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9166

# CERTIFICATE OF DEATH

09181

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12</u> TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 1/2</u> years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Ranier</u>		<u>16-16-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91</u> <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>4517 - 32nd Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) (Type or Print) <u>Olive</u> <u>Almonia</u> <u>Croson</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept.</u> <u>16</u> <u>19 55</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>3/25/1887</u>	<b>9. AGE last birthday</b> <u>68</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>- -</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Sprakes</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lura Sprakes</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>- -</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>443X</u> IMMEDIATE CAUSE (A) <u>Hypertensive arteriosclerotic cardiovascular disease</u>						<u>3 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis - general</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Parkinson's Disease</u>						<u>6 yrs.</u>	
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>Apr. 28</u> , 19 <u>52</u> , to <u>Sept. 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 16</u> , 19 <u>55</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Dr. V. Juerman</u> <u>V. Juerman, M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Deer's Head State Hospital</u> <u>Salisbury, Md.</u>		<b>DATE SIGNED</b> <u>9/16/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>9/19/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Hope</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Waxpool Va</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>Sept 19, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary W. Galloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Bascha Sosa</u>		<b>ADDRESS</b> <u>Hyattsville Md</u>	



CERTIFICATE OF DEATH

2188

Age 100

1. Name of deceased (Print or type)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Date of death (Month, day, year)

6. Time of death (Hour, minute)

7. Cause of death (Print or type)

8. Place of death (City, State, Country)

9. Signature of physician (Print or type)

10. Signature of registrar (Print or type)

11. Signature of informant (Print or type)

12. Signature of witness (Print or type)

13. Signature of medical examiner (Print or type)

14. Signature of coroner (Print or type)

15. Signature of jury (Print or type)

16. Signature of jury (Print or type)

17. Signature of jury (Print or type)

18. Signature of jury (Print or type)

19. Signature of jury (Print or type)

20. Signature of jury (Print or type)

21. Signature of jury (Print or type)

22. Signature of jury (Print or type)

23. Signature of jury (Print or type)

24. Signature of jury (Print or type)

25. Signature of jury (Print or type)

26. Signature of jury (Print or type)

27. Signature of jury (Print or type)

28. Signature of jury (Print or type)

29. Signature of jury (Print or type)

30. Signature of jury (Print or type)

BUREAU V. 2

SEP 22 1933

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9167

## CERTIFICATE OF DEATH

09182

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		<u>most of life</u>		TOWN <u>Salisbury</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Peninsula General Hospital</u>				<u>403 E. Rose Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>NEWBORN</u> (Middle) <u>Curtis</u> (Last)				Sept. 18 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	AA	Married	7-2-1917	38 yrs.	Months 2	Days 16	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Preparer</u>		<u>Conley's Cleaner</u>		<u>Hebron, Wicomico Co. Md.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward Taylor</u>				<u>Edith Curtis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>WWII</u>		<u>220-10-9846</u>		<u>403 E. Rose St.</u> <u>Mrs. Maggie Curtis Salisbury, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>15. MEDICAL CERTIFICATION</b>			
592X IMMEDIATE CAUSE (A)				<u>Renal Failure Uremia</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Glomerulonephritis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>?</u>			
DUE TO (C)				<u>Hypertension</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				INTERVAL BETWEEN ONSET AND DEATH			
				<u>2 weeks</u>			
				<u>8 months</u>			
				<u>?</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>21</u>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 24</u> , 19 <u>55</u> , to <u>Sept. 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 17</u> , 19 <u>55</u> , and that death occurred at <u>3:20 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>D. Herbert Sewbly</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>9/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-22-55</u>		<u>Green Acres Mem. Park</u>		<u>Salisbury, Wicomico Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Sept. 21, 1955</u>		<u>Mary H. Holloway</u>		<u>Mary A. Stewart</u>		<u>324 E. Church St. Salisbury, Maryland.</u>	



9168

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Charm</u>		OR TOWN <u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print) <u>Andrew</u> (First) <u>Dashiell</u> (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>9</u> <u>18</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widower</u>	8. DATE OF BIRTH: <u>Sept 18 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Waterman</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Sidney Dashiell</u>				14. MOTHER'S MAIDEN NAME: <u>Virginia Winsor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Harold White Phoenician Anne Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Coronary Heart Failure</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Cerebral Hemorrhage</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension &amp; Atherosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/17/55</u> , 19 <u>55</u> , to <u>9/18/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/18/55</u> , 19 <u>55</u> , and that death occurred at <u>10:05</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Harold White</u>				ADDRESS <u>1136 Church St</u>		DATE SIGNED <u>9/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Oriole Cemetery</u>		LOCATION (City, town, or county) (State) <u>Oriole Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9/17-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Phoenician Anne Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 21 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09184

9169

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		8 days		TOWN <u>Salisbury</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)			
91 <u>Deer's Head State Hospital</u>				1 <u>515 Collins Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Garfield</u>		(Middle) <u>Henry</u>		(Last) <u>Dashiell</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Colored	Married	6/10/1894	61 yrs.	Months 2	Days 29	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Brickyard</u>		<u>White Haven, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Dashiell</u>				<u>Henrietta Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Yes		WW-1-		<u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>15. MEDICAL CERTIFICATION</b>	
160X IMMEDIATE CAUSE (A) <u>Squamous cell carcinoma of left maxillary</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>antrum with metastasis</u>						1 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
0							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>Sept. 1</u> , 19 <u>55</u> , to <u>Sept. 9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 8</u> , 19 <u>55</u> , and that death occurred at <u>12:20AM</u> , from the causes and on the date stated above.							
SIGNATURE		R. J. Gore, M.D.		Deer's Head State Hospital		DATE SIGNED	
<u>[Signature]</u>		M.D.		<u>Salisbury, Maryland</u>		<u>9/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>9-13-55</u>		<u>Green Acres Memorial Park</u>		<u>Salisbury, Wicomico Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>EP 13 1955</u>		<u>Mary H. Holloway</u>		<u>Mary A. Stewart</u>		<u>324 E. Church St. Salisbury, Md.</u>	
DATE							

# CERTIFICATE OF DEATH

Form 100-100

Official Statement of Cause of Death

Name of Deceased: [Name]

Age: [Age]

Sex: [Sex]

Date of Death: [Date]

Place of Death: [Place]

Time of Death: [Time]

Signature of Physician: [Signature]

Signature of Coroner: [Signature]

Signature of Registrar: [Signature]

Signature of Medical Examiner: [Signature]

Signature of Health Officer: [Signature]

Signature of County Clerk: [Signature]

Signature of City Clerk: [Signature]

Signature of Mayor: [Signature]

Signature of Governor: [Signature]

Signature of President: [Signature]

Signature of Vice President: [Signature]

Signature of Speaker of House: [Signature]

Signature of President of Senate: [Signature]

Signature of Chief Justice: [Signature]

Signature of Associate Justice: [Signature]

Signature of District Judge: [Signature]

Signature of Circuit Judge: [Signature]

Signature of Appellate Judge: [Signature]

Signature of Supreme Court: [Signature]

Signature of Justices: [Signature]

Signature of Clerks: [Signature]

Signature of Attorneys: [Signature]

Signature of Witnesses: [Signature]

Signature of Jurors: [Signature]

Signature of Jury: [Signature]

Signature of Verdict: [Signature]

Signature of Court: [Signature]

Name of Deceased: [Name]

Age: [Age]

Sex: [Sex]

Date of Death: [Date]

Place of Death: [Place]

Time of Death: [Time]

Signature of Physician: [Signature]

Signature of Coroner: [Signature]

Signature of Registrar: [Signature]

Signature of Medical Examiner: [Signature]

Signature of Health Officer: [Signature]

Signature of County Clerk: [Signature]

Signature of City Clerk: [Signature]

Signature of Mayor: [Signature]

Signature of Governor: [Signature]

Signature of President: [Signature]

Signature of Vice President: [Signature]

Signature of Speaker of House: [Signature]

Signature of President of Senate: [Signature]

Signature of Chief Justice: [Signature]

Signature of Associate Justice: [Signature]

Signature of District Judge: [Signature]

Signature of Circuit Judge: [Signature]

Signature of Appellate Judge: [Signature]

Signature of Supreme Court: [Signature]

Signature of Justices: [Signature]

Signature of Clerks: [Signature]

Signature of Attorneys: [Signature]

Signature of Witnesses: [Signature]

Signature of Jurors: [Signature]

Signature of Jury: [Signature]

Signature of Verdict: [Signature]

Signature of Court: [Signature]

BUREAU V. S.

SEP 13 1955

RECEIVED

Green House Medical Park, Baltimore, Maryland, U.S.A.

8-13-55

8-13-55

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09185

9170

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		TOWN <u>Marion Station</u>	19X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Peninsula General Hospital</u>			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>FANNIE</u>		<u>Sept. 24 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept 4, 1863</u>
		9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Housewife</u>		<u>At Home</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Samuel Pull</u>		<u>Catherine Gunby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<u>9</u>		<u>-</u>	
17. INFORMANT & ADDRESS			
<u>Mrs Eva Mills, Marion Station, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>6 days</u>	
422.1 IMMEDIATE CAUSE (A) <u>Industrial Obstruction</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis C.V.D.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<input type="checkbox"/>			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>9:20</u> , 19 <u>55</u> , to <u>9:24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9:24</u> , 19 <u>55</u> , and that death occurred at <u>10:15</u> AM, from the causes and on the date stated above.			
SIGNATURE <u>H. K. B. B.</u>		DATE SIGNED <u>9-25-55</u>	
ADDRESS (Street, city, town, state)			
M.D. <u>226 N. Duane St.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	<u>9-27-55</u>	<u>St Pauls Cemetery</u>	<u>Marion Station, Md.</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE <u>9-26-55</u>	<u>Mary W. Hollonay</u>	<u>Bradshaw &amp; Sons, Crisfield, Md.</u>	

# NOTIFICATION

1. This form is to be filled out by the physician or other person who has attended the deceased, and is to be filed with the local health officer, who will forward it to the State Department of Health, Baltimore, Md.

2. The information furnished on this form is for the purpose of determining the cause of death, and is not to be used for any other purpose.

3. The information furnished on this form is to be used for the purpose of determining the cause of death, and is not to be used for any other purpose.

4. The information furnished on this form is to be used for the purpose of determining the cause of death, and is not to be used for any other purpose.

## CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1. DECEASED'S NAME (Last, first, and middle)

MARYLAND

1. DECEASED'S NAME (Last, first, and middle)

MARYLAND

1. DECEASED'S NAME (Last, first, and middle)

MARYLAND

1. DECEASED'S NAME (Last, first, and middle)

MARYLAND

1. DECEASED'S NAME (Last, first, and middle)

MARYLAND

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MARYLAND

1. DECEASED'S NAME (Last, first, and middle)

MARYLAND

BUREAU V. 8

SEP 28 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09186

9209

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Gesterville</u>		<u>Lifetime</u>		TOWN <u>Gesterville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
NETTIE DAVIS				Sept. 26 1955			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
Female		White		Married		May 16, 1877	
						78 yrs.	
						4	
						18	
						Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<u>Housewife</u>				<u>Own Home</u>		<u>Gesterville, Md.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Isaac Roberts</u>				<u>Julia Roberts</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>			
No				—			
				<b>INFORMANT &amp; ADDRESS</b>			
				<u>Harry Davis - Gesterville, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.0 IMMEDIATE CAUSE (A)						Acute Cardiac Failure	
ANTECEDENT CAUSE(S) DUE TO						1 Hour	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						Arteriosclerotic Heart Disease	
STATING UNDERLYING CAUSE LAST, DUE TO (C)						10 years	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						Generalized Arteriosclerosis	
10 years							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
0							
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from</b> Nov 21, 1947, <b>to</b> Sept 26, 1955, <b>that I last saw the deceased</b> alive on Sept 26, 1955, <b>and that death occurred at</b> 1:30 P.M. <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)			
<u>Richard H. Saunders, M.D.</u>				<u>Antebell, Md.</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
<u>Burial</u>				<u>9/28/55</u>		<u>Oak Grove Cemetery, Gesterville, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<u>Sept. 30, 1955</u>				<u>Mary H. Holloway</u>		<u>C. H. Mesick, Director, Md.</u>	



# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHAMORE 15

NAME OF DECEASED  
 HETTIE  
 DATE OF DEATH  
 1955

PLACE OF DEATH  
 1955

DATE OF BIRTH  
 1955  
 PLACE OF BIRTH  
 1955  
 OCCUPATION  
 1955  
 CAUSE OF DEATH  
 1955  
 MEDICAL EXAMINER  
 1955

BUREAU V. E.

SEP 30 1955

RECEIVED

1955  
 1955  
 1955

9171

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Delmar</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General</u>				STREET ADDRESS (If rural give location) <u>Rt # 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Elmer</u> <u>Downs</u>				DATE OF DEATH: <u>9</u> <u>18</u> <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>7-15-09</u>	
9. AGE last birthday <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>FARMING</u>		11. BIRTHPLACE (State or foreign country): <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME: <u>MANNIE DOWNS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Rhyspa Downes, Laurel, Delaware</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>581.0</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C) <u>PORTAL CIRRHOSIS OF LIVER</u>				<u>1-2 months</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>INANITION (nutritional failure)</u>				<u>2-3 months</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5</u> , 19 <u>54</u> , to <u>death</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/1/55</u> , 19 <u>55</u> , and that death occurred at <u>8:16</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Ernest M. Larmore</u>		M. D.		ADDRESS <u>Delmar, Del</u>		DATE SIGNED <u>9/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>9/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>EPWORTH CHURCH CEN</u>		LOCATION (City, town, or county) (State) <u>NEAR LAUREL, Delaware</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-21-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollerway</u>		24. FUNERAL DIRECTOR <u>J. Harvey Williams</u>		ADDRESS <u>Edwardsburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 23 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9172

## CERTIFICATE OF DEATH

09188

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write name and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write name and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Princess Anne</u>		19X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Olga</u>				<u>September 2, 1965</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Mar. 13, 1883</u>	
9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>md.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>Will Marriner</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Pusey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>9-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Gladys Ford, Princess Anne, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>						3 yrs. 2.	
ANTECEDENT CAUSE (B) <u>Coronary Artery Heart Disease</u>						" "	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension, Arterial Cerebral Ischemia</u>						1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/11</u> , 19 <u>55</u> , to <u>9/2</u> , 19 <u>65</u> , that I last saw the deceased alive on <u>9/2</u> , 19 <u>65</u> , and that death occurred at <u>12:55</u> M, from the causes and on the date stated above.							
SIGNATURE <u>David J. Gilmore</u>				ADDRESS <u>Salisbury, Md.</u>		DATE SIGNED <u>Sept. 2, 1965</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>Sept 4, 1965</u>		NAME OF CEMETERY OR CREMATORY: <u>Andrews Cemetery</u>		LOCATION (City, town or county) (State): <u>Princess Anne md</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>9-6-65</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>James Thurman</u>		ADDRESS: <u>Princess Anne</u>	

RECEIVED

SEP 8 1955

BUREAU V. S.



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09189

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

9173

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore City</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Salisbury</b>		<b>3 yrs 5 months</b>		TOWN <b>715 W. Fayette St., Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Deer's Head State Hospital</b>				STREET ADDRESS (If rural give location) <b>715 W. Fayette Street</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Loyal</b>		(Middle)		(Last) <b>Glenn</b>		(Month) <b>9</b> (Day) <b>1</b> (Year) <b>19 55</b>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Male</b>	<b>White</b>	<b>Single</b>	<b>11/7/1876</b>	<b>78</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Unknown</b>		<b>--</b>		<b>Pennsylvania</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>William Glenn</b>				<b>Julia Allen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>Unk.</b>		<b>None</b>		<b>Hospital Records</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Cerebral thrombosis</b>						<b>8 days</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO						<b>?</b>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Apr. 2</b> , 19 <b>52</b> , to <b>Sept. 1</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Sept. 1</b> , 19 <b>55</b> , and that death occurred at <b>9:05 P.M.</b> from the causes and on the date stated above.							
SIGNATURE		L.V. Maldve, M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<b>W. Maldve</b>		<b>Deer's Head State Hospital</b>		<b>Salisbury, Maryland</b>		<b>9/2/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<b>Removal</b>		<b>Sept. 6/1955</b>		<b>Crematorium Bld</b>		<b>Balt. 4nd.</b>	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>Sept. 8, 1955</b>		<b>Mary W. Holloway</b>		<b>Booker Pluech</b>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

100-100000

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

# CERTIFICATE OF DEATH

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BUREAU V. S.

SEP 8 1965

RECEIVED

*Handwritten signature and notes*

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9, Film G186 9-16-55 et

09190

9174

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
12 TOWN <u>Salisbury 1 Hr.</u>		1 Hr.		12 TOWN <u>Salisbury</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		STREET ADDRESS		(If rural give location)	
81 <u>Peninsula General Hospital</u>				113 Walnut St.,		12	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>NANCY MURPHY GORDY</u>				<u>9 8 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Oct, 31, 1881</u>	<u>73 7/4</u>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>House Keeper</u>			<u>Own home</u>		<u>Maryland</u>		<u>U.S.A.</u>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>William S. Gordy Sr.,</u>				<u>Virginia Brewington</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>None</u>		<u>Graham Gumby Jr. Salisbury, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>331X IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>Revol. Hemorrhage</u>						<u>2 hrs</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST.</b>							
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<u>0</u>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
		<u>M.</u>					
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>			
<u>Fred R. Gorman</u>		<u>Salisbury, Md.</u>		<u>9/10/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>	<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)		
<u>Burial</u>		<u>9/9/55</u>	<u>Parsons Cemetery</u>		<u>Salisbury, Maryland</u>		
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>Sept 13, 1955</u>		<u>Mary St. Holloway</u>		<u>The Hill &amp; Johnson Co. Salisbury, Md.</u>			
				<u>Norman F. Baker</u>			

# CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
William S. Jones		Male		45		1910		Maryland		Baltimore, Md.		Heart Disease		1955		Baltimore, Md.		10:00 AM		J. S. Smith		A. B. Jones	

BUREAU V. S.

SEP 18 1955

RECEIVED

The Bill & Johnson Co., Baltimore, Md.

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE CAUSE OF DEATH IS CORRECTLY STATED. IF THE CAUSE OF DEATH IS NOT KNOWN, IT SHOULD BE STATED AS SUCH. IF THE DECEASED WAS A MEMBER OF THE ARMY, NAVY, AIR FORCE, OR MARINE CORPS, THIS SHOULD BE STATED. IF THE DECEASED WAS A MEMBER OF THE COAST GUARD, THIS SHOULD BE STATED. IF THE DECEASED WAS A MEMBER OF THE NATIONAL GUARD, THIS SHOULD BE STATED. IF THE DECEASED WAS A MEMBER OF THE NATIONAL RESERVE, THIS SHOULD BE STATED. IF THE DECEASED WAS A MEMBER OF THE NATIONAL DEFENSE, THIS SHOULD BE STATED. IF THE DECEASED WAS A MEMBER OF THE NATIONAL GUARD, THIS SHOULD BE STATED. IF THE DECEASED WAS A MEMBER OF THE NATIONAL RESERVE, THIS SHOULD BE STATED. IF THE DECEASED WAS A MEMBER OF THE NATIONAL DEFENSE, THIS SHOULD BE STATED.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9175  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03491st.  
No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD.</u> COUNTY <u>S.C.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>2 Mos</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Charleston</u> <u>77X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location) <u>50 1/2 Cannon St.</u> ✓			
3. NAME OF DECEASED: (First) <u>Henry</u>		(Middle) <u>Franklin</u>		(Last) <u>Green</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9-</u> <u>3-</u> <u>19 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>O</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Dec. 18, 1933</u>		9. AGE last birthday: <u>21</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Freezing Plant</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Poultry</u>		11. BIRTHPLACE (State or foreign country): <u>Charleston, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Alexander Green</u>				14. MOTHER'S MAIDEN NAME: <u>Elsie Small</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>248 50 3526</u>		17. INFORMANT & ADDRESS: <u>50 1/2 Cannon St</u> <u>Mr. Alexander Green</u> <u>Charleston, S.C.</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>981X</u> Immediate cause (a) <u>Gunshot wound of left chest and abdomen- hemo-thorax</u> <u>DUE TO</u> <u>left and hemo-peritoneum.</u>				<u>3 ho.urs.</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home.</u>		21c. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9</u> <u>3</u> <u>55</u> <u>2A M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Shot during a quarrel.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Emile Ruge</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-6-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>9/8/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Resbyterian Cemetery</u>	
LOCATION (City, town, or county) (State): <u>Charleston, S.C.</u>		24. FUNERAL DIRECTOR: <u>J.F. STEWART FUNERAL HOME</u>		ADDRESS: <u>Salisbury, Md.</u>	
DATE REC'D BY LOCAL REG. <u>9-6-55</u>		REGISTRAR'S SIGNATURE: <u>Maryell Holloway</u>			



BUREAU A.S.

RECEIVED

STEWART FURNAL HOME

SEP 8 1935

Yes 248 50 5880 Mr. Alexander Green Charleston, S.C.

50 Cannon St

Male (Small)

Charleston, S.C.

President Prince Pontier

Dec. 18, 1935

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

9176

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 18&amp;21 Film G187 10-6-55 am

09192

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>6 WEEKS</u>		TOWN <u>OCEAN CITY</u> <u>23 X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>82 Peninsula General Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Annie Pointer. Hall</u>				<u>Sept. 25 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>		<u>7 1883</u>	<u>71</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>OWN HOME</u>		<u>BERLIN, MD R.F.D.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM ZULLEN</u>				<u>HETTIE POINTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>MR. HARRY HALL, SALISBURY, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>904.0 (B) Fractured left hip</u>				<u>35 days</u>			
ANTECEDENT CAUSE(S) (B)							
<u>(B) Lobular pneumonia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<u>Uremia</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>8-15-1955</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
		<u>Home</u>		<u>Ocean City</u>		<u>23 Md.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<u>8-15-1955</u> M.		<input type="checkbox"/> <input type="checkbox"/>		<u>Fall</u>			
22. I hereby certify that I attended the deceased from <u>8-15-55</u> , to <u>9-21-55</u> , that I last saw the deceased alive on <u>9-21-55</u> , and that death occurred at <u>2:28</u> A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>H. Brail</u>				<u>M.D. 226 N. Dunbar St</u>			
DATE SIGNED				DATE SIGNED			
<u>9-21-55</u>				<u>9-21-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>9/27/55</u>		<u>ODD FELLOWS</u>		<u>BISHOPVILLE MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept. 28, 1955</u>		<u>Mary H. Holloway</u>		<u>Anna D. Burboze</u>		<u>Berlin Md.</u>	

1913

MASSACHUSETTS DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

Form No. 1

1. Name of deceased

John J. Connelley

2. Date of death

Sept 29, 1955

3. Place of death

Home

4. Cause of death

Heart

5. Age at death

65

6. Sex

Male

7. Race

White

8. Marital status

Married

9. Occupation

None

10. Signature of physician

Dr. J. J. Connelley

11. Signature of registrar

John J. Connelley

12. Date of registration

Sept 29, 1955

13. Place of registration

Home

14. Signature of informant

John J. Connelley

15. Date of completion

Sept 29, 1955

BUREAU V. S.

SEP 29 1955

RECEIVED

OFFICE

SEP 29 1955

RECEIVED

SEP 29 1955

RECEIVED

SEP 29 1955

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9210

## CERTIFICATE OF DEATH

09193

Reg. Dist. No. 33✓

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Eden</u>		<u>20 Yrs.</u>		TOWN <u>Eden</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eden</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>NINA</u> (First) <u>ELIZABETH</u> (Middle) <u>HALLOCK</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>9</u> (Day) <u>24</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Jan 9, 1895</u>		<b>9. AGE last birthday</b> <u>60</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>N.Y.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Claude Barry</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Hardy</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-34-5007</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>116 Hobart Ave., 5</u> <u>Mrs. Lola M. Bulford, Syracuse, N.Y.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage -</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Malignant Hypertension</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>  </u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>  </u>				<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>  </u>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>2D. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 9, 1955</u> , <b>to</b> <u>9-24-1955</u> , <b>that I last saw the deceased alive on</b> <u>9-22-1955</u> , <b>and that death occurred at</b> <u>1A</u> M., <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Lee L. Lawry</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Fruitland, Md.</u>		<b>DATE SIGNED</b> <u>9-25-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>9/28/1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Hudson Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Hudson, New York</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Sept. 28, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Hill &amp; Johnson Co. Salisbury, Md.</u> <u>Norman F. Baker</u>			

CERTIFICATE OF DEATH

0210

Reg. Dist. No.

2. Date and place of death, or discovery

Mr. Maryland

0210

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BUREAU V. 2

SEP 28 1955

RECEIVED

Hudson, New York

0210

0210

The Hill & Johnson Co., Baltimore, Md.



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be secured within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09194

9177

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <b>Salisbury</b>		Most of life		TOWN <b>Salisbury</b>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 At home - 107 Second St.				107 Second Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Annie</b> (Middle) <b>Purnell</b> (Last) <b>Hauton</b>				(Month) <b>9</b> (Day) <b>20</b> (Year) <b>19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	A.A.	Married	2-10-1890	65 yrs.	Months <b>7</b>	Days <b>10</b>	Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic		Housework		Salisbury, Wicomico Co. Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Levin Purnell				Sophie Birkhead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		No		107 Second St. Mrs. Thelma Matthews, Salisbury, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334X IMMEDIATE CAUSE (A) <b>Cerebral Sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>undetermined</b>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
0				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <b>Oct 20, 19 54</b> , to <b>Sept 20, 19 55</b> , that I last saw the deceased alive on <b>20 Sept 19 55</b> , and that death occurred at <b>8:30 P</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Purnell, M.D.</b>				ADDRESS (Street, city, town, state) <b>652 Wm. Salisbury Md.</b>		DATE SIGNED <b>23 Sept 55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-25-55		Green Acres Memorial Park		Salisbury, Wicomico Co. Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>Sept. 26, 1955</b>		<b>Mary T. Hollaway</b>		<b>Mary A. Stewart</b>		<b>324 E. Church St. Salisbury, Md.</b>	





1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09195

9178

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>Most of life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Peninsula General Hospital</b>		STREET ADDRESS (If rural give location) <b>720 Lake Street</b>					
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>Annie</b> (Middle) <b>Leah</b> (Last) <b>Hearn</b>				Month <b>9</b> Day <b>30</b> Year <b>1955</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>A.A.</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widow</b>	<b>8. DATE OF BIRTH</b> <b>5-9-1871</b>	<b>9. AGE last birthday</b> <b>84</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>21</b>	<b>IF UNDER 24 HRS.</b> Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Salisbury, Wicomico Co., Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>George Henry West</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Hettie Smith</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>720 Lake Street</b> <b>Mrs. Goldie Twilley, Salisbury, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.0 IMMEDIATE CAUSE</b> (A) <b>Arteriosclerotic heart disease</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <b>Cerebrovascular accident</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <b>Senility</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 1/25, 1953, to 9/22, 1955, that I last saw the deceased alive on 9/22, 1955, and that death occurred at 9:30 P.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Andrew C. Mitchell</i>		<b>M.D.</b>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>10-3-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Houston Cemetery</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Salisbury, Wicomico Co., Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Oct. 5, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary T. Hallways</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Mary A. Stewart</i>		<b>ADDRESS</b> <b>320 E. Church St</b>	

# CERTIFICATE OF DEATH

Reg. No. 100

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

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BUREAU V. E.

OCT 5 1955

RECEIVED

Place of Birth

Place of Birth

Place of Birth

Place of Birth

RECEIVED



**INSTRUCTIONS**

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9179

**CERTIFICATE OF DEATH**

09196

Reg. Dist. No. 337

Dr. Gramse

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Harford Co.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (In this place) <b>12</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Belair</b>		<b>12 X - 2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>224 East Church St</b>		STREET ADDRESS <b># 1 William St</b>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>JOSEPH CHANDLER HENDRICKSON</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>SEPT 3 rd 19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Nov. 30, 1898</b>	<b>9. AGE last birthday</b> <b>56</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>9</b> Days <b>3</b>	<b>IF UNDER 24 HRS.</b> Hours <b>3</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk -Auto Accessory Co.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Wilmington, Delaware</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William P. Hendrickson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Susan Chandler</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Lucille L. Hendrickson (Wife) # 1, William St. Belair, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>15. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b> <b>Coronary Occlusion</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Several</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 9/3, 1955, to 9/3, 1955, that I last saw the deceased alive on 9/3, 1955, and that death occurred at 3:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Frederic R. Gramse</i>				<b>DATE SIGNED</b> <b>Sept 5 / 55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>NAME OF CEMETERY OR CREMATORY</b> <b>Lower Brandywine Cemetery</b>			
<b>DATE THEREOF</b> <b>Sept. 6, 1955</b>		<b>LOCATION (City, town, or county)</b> <b>Wilmington, Delaware</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>			
<b>24. REC'D BY REGISTRAR</b> <b>Sept. 7, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>ADDRESS</b> <b>SALISBURY MARYLAND</b>			

# CERTIFICATE OF DEATH

Reg. No. 1111

1. Name of deceased: **William F. Henderson**

2. Date of death: **Nov. 30, 1955**

3. Place of death: **Home**

4. Cause of death: **Heart Disease**

5. Manner of death: **Natural**

6. Age at death: **61**

7. Sex: **Male**

8. Race: **White**

9. Marital status: **Married**

10. Occupation: **Engineer**

11. Date of birth: **Nov. 30, 1894**

12. Place of birth: **Philadelphia, Pa.**

13. Education: **High School**

14. Name of physician: **Dr. J. H. Smith**

15. Name of funeral home: **William F. Henderson**

16. Name of informant: **William F. Henderson**

17. Name of informant: **William F. Henderson**

18. Name of informant: **William F. Henderson**

19. Name of informant: **William F. Henderson**

20. Name of informant: **William F. Henderson**

21. Name of informant: **William F. Henderson**

22. Name of informant: **William F. Henderson**

23. Name of informant: **William F. Henderson**

24. Name of informant: **William F. Henderson**

25. Name of informant: **William F. Henderson**

26. Name of informant: **William F. Henderson**

27. Name of informant: **William F. Henderson**

28. Name of informant: **William F. Henderson**

29. Name of informant: **William F. Henderson**

30. Name of informant: **William F. Henderson**

31. Name of informant: **William F. Henderson**

32. Name of informant: **William F. Henderson**

33. Name of informant: **William F. Henderson**

34. Name of informant: **William F. Henderson**

35. Name of informant: **William F. Henderson**

36. Name of informant: **William F. Henderson**

37. Name of informant: **William F. Henderson**

38. Name of informant: **William F. Henderson**

39. Name of informant: **William F. Henderson**

39. Name of informant: **William F. Henderson**

40. Name of informant: **William F. Henderson**

40. Name of informant: **William F. Henderson**

41. Name of informant: **William F. Henderson**

41. Name of informant: **William F. Henderson**

42. Name of informant: **William F. Henderson**

BUREAU V. S.

SEP 7 1955

RECEIVED

NOV 24 1955



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09197

9180

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bishop</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>R.R.</u>			
3. NAME OF DECEASED: (First) <u>Daisy</u> (Middle) <u>Ma</u> (Last) <u>Hudson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>September 17 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Feb 19, 1895</u>	
9. AGE last birthday <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Joshua Morris</u>		14. MOTHER'S MARDEN NAME: <u>Anna Mary Hickman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Edgar Hudson, Bishop, Md</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE				(A) <u>Cerebral Hemorrhage</u>		<u>3 days</u>	
ANTECEDENT CAUSE (S)				DUE TO (B) <u>Cerebral Atherosclerosis</u>		<u>symptoms 2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <u>Hypertension, essential</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 15, 1953</u> to <u>Sept 17, 1953</u> , that I last saw the deceased alive on <u>Sept 16, 1953</u> , and that death occurred at <u>6:45A M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David J. Schure</u>		ADDRESS <u>Salisbury Md</u>		DATE SIGNED <u>Sept 17, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>9-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bishopville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-19-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Peter Whaley</u>		ADDRESS <u>Salisbury Del</u>	



BUREAU V. S.

SEP 21 1955

RECEIVED

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

9181

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# CERTIFICATE OF DEATH

09198

Dr. Ellis

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
CITY <i>Wicomico</i>		STATE <i>Maryland</i>		COUNTY <i>Wicomico</i>			
(If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Salisbury</i>				OR TOWN <i>Delmar</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location) <i>203 East St.</i>			
<b>3. NAME OF DECEASED</b> (First) <i>CHARLES GRANVILLE HUNTINGTON</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>September 6 1955</i>			
(Type or Print) <i>Rev. Charles Huntington</i>							
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 9, 1896</i>	9. AGE last birthday <i>58</i> Yrs.	10. UNDER 1 YEAR Months <i>11</i> Days <i>27</i>	11. UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Minister &amp; Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painting</i>		11. BIRTHPLACE (State or foreign country) <i>Near Parsonsburg, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Wesley Huntington</i>				14. MOTHER'S MAIDEN NAME <i>Miltelda (Matilda) Ella Collins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Yes</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mrs. Bessie M. Huntington (Wife) 203 East St. Delmar, Maryland</i>			
(If Yes, give war or dates of service)							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <i>Myocardial Infarct, acute</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic coronary thrombosis</i>						<i>110</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-6</i> , 19 <i>55</i> , to <i>9-6</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>9-6</i> , 19 <i>55</i> , and that death occurred at <i>6:15</i> P.M., from the causes and on the date stated above.							
SIGNATURE <i>William B. Ellis Jr.</i>		M.D.		ADDRESS (Street, city, town, state) <i>Salisbury, Md.</i>		DATE SIGNED <i>9-6-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Sept. 9, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Parsonsburg, Cemetery</i>		LOCATION (City, town, or county) (State) <i>Parsonsburg, Maryland</i>	
24. REC'D BY REGISTRAR <i>Sept. 8, 1955</i>		REGISTRAR'S SIGNATURE <i>Mary J. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY &amp; COMPANY</i> ADDRESS <i>SALISBURY MARYLAND</i>			

# CERTIFICATE OF DEATH

ST. MARY'S

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BUREAU V. 2

SEP 8 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9182

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09199

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Delaware</b>		COUNTY <b>Sussex</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>DOA</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Delmar</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Peninsula General Hospital</b>				STREET ADDRESS (If rural give location) <b>109 Lincoln Avenue</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Samuel Jarrell</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>September 27 1955</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>January 6, 1906</b>	9. AGE last birthday <b>49</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Farm</b>		11. BIRTHPLACE (State or foreign country): <b>Wheeling, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>No data</b>				14. MOTHER'S MAIDEN NAME: <b>No data</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <b>WW</b>				16. SOCIAL SECURITY NO. <b>221-09-4349</b>		17. INFORMANT & ADDRESS: <b>Rebecca Jarrell, Delmar, Delaware</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <b>420.0</b>						<b>2 hours</b>	
ANTECEDENT CAUSE (B) DUE TO <b>Acute pulmonary edema</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<b>3 years?</b>	
DUE TO <b>Arteriosclerotic heart disease with R. + L. ventricular failure</b>							
DUE TO <b>Arteriosclerosis generalized</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 20, 1955</b> , to <b>Sept 27, 1955</b> , that I last saw the deceased alive on <b>Sept 25, 1955</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>		M. D. <b>Delmar Md.</b>		DATE SIGNED <b>9-29-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Sept. 30, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		LOCATION (City, town, or county) (State) <b>Near Delmar, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>9-30-55</b>		REGISTRAR'S SIGNATURE <b>Mary W. Holloman</b>		24. FUNERAL DIRECTOR ADDRESS <b>J.J. Frampton and Son, Federalsburg, Md.</b>			

RECEIVED

OCT 3 1955

BUREAU V. B.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be retained within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09201

9183

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Millsboro</u> <u>46X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last) <u>Joseph</u>				<u>September 30</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>		<u>September 29 1955</u>	Yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
						<u>U.S.A.</u>	
13. FATHER'S NAME <u>Harley Clinton Joseph</u>				14. MOTHER'S MAIDEN NAME <u>Mina Grace Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Father &amp; Mother, Millsboro Del.</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
1. IMMEDIATE CAUSE (A) <u>762.5 Atelectasis, Congenital</u>				INTERVAL BETWEEN ONSET AND DEATH			
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>9/29</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/29/55</u> to <u>9/30/55</u> , that I last saw the deceased alive on <u>9/10/55</u> , and that death occurred at <u>9:45</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>10/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>10/1/55</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital, Salisbury, Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	
DATE <u>10-3-55</u>							

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10-15-55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

# CERTIFICATE OF DEATH

9188

Page 1 of 1

1. NAME OF DECEASED: [illegible]

2. PLACE OF DEATH: [illegible]

3. DATE OF DEATH: [illegible]

4. TIME OF DEATH: [illegible]

5. PLACE OF BIRTH: [illegible]

6. SEX: [illegible]

7. AGE: [illegible]

8. OCCUPATION: [illegible]

9. CAUSE OF DEATH: [illegible]

10. MANNER OF DEATH: [illegible]

11. SIGNATURE OF PHYSICIAN: [illegible]

12. SIGNATURE OF REGISTRAR: [illegible]

13. SIGNATURE OF WITNESS: [illegible]

14. SIGNATURE OF DECEASED: [illegible]

15. SIGNATURE OF NEXT OF KIN: [illegible]

16. SIGNATURE OF CLERK: [illegible]

17. SIGNATURE OF JUDGE: [illegible]

18. SIGNATURE OF SHERIFF: [illegible]

19. SIGNATURE OF CORONER: [illegible]

20. SIGNATURE OF JURY: [illegible]

21. SIGNATURE OF JURY: [illegible]

22. SIGNATURE OF JURY: [illegible]

23. SIGNATURE OF JURY: [illegible]

24. SIGNATURE OF JURY: [illegible]

25. SIGNATURE OF JURY: [illegible]

26. SIGNATURE OF JURY: [illegible]

27. SIGNATURE OF JURY: [illegible]

28. SIGNATURE OF JURY: [illegible]

29. SIGNATURE OF JURY: [illegible]

30. SIGNATURE OF JURY: [illegible]

31. SIGNATURE OF JURY: [illegible]

32. SIGNATURE OF JURY: [illegible]

33. SIGNATURE OF JURY: [illegible]

34. SIGNATURE OF JURY: [illegible]

35. SIGNATURE OF JURY: [illegible]

36. SIGNATURE OF JURY: [illegible]

37. SIGNATURE OF JURY: [illegible]

38. SIGNATURE OF JURY: [illegible]

39. SIGNATURE OF JURY: [illegible]

40. SIGNATURE OF JURY: [illegible]

41. SIGNATURE OF JURY: [illegible]

42. SIGNATURE OF JURY: [illegible]

43. SIGNATURE OF JURY: [illegible]

44. SIGNATURE OF JURY: [illegible]

45. SIGNATURE OF JURY: [illegible]

46. SIGNATURE OF JURY: [illegible]

47. SIGNATURE OF JURY: [illegible]

48. SIGNATURE OF JURY: [illegible]

49. SIGNATURE OF JURY: [illegible]

50. SIGNATURE OF JURY: [illegible]

51. SIGNATURE OF JURY: [illegible]

52. SIGNATURE OF JURY: [illegible]

53. SIGNATURE OF JURY: [illegible]

54. SIGNATURE OF JURY: [illegible]

55. SIGNATURE OF JURY: [illegible]

56. SIGNATURE OF JURY: [illegible]

57. SIGNATURE OF JURY: [illegible]

58. SIGNATURE OF JURY: [illegible]

59. SIGNATURE OF JURY: [illegible]

60. SIGNATURE OF JURY: [illegible]

61. SIGNATURE OF JURY: [illegible]

62. SIGNATURE OF JURY: [illegible]

63. SIGNATURE OF JURY: [illegible]

64. SIGNATURE OF JURY: [illegible]

65. SIGNATURE OF JURY: [illegible]

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83. SIGNATURE OF JURY: [illegible]

84. SIGNATURE OF JURY: [illegible]

85. SIGNATURE OF JURY: [illegible]

86. SIGNATURE OF JURY: [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE. 18

09202  
Reg. Dist.

Reg. Dist.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>	LENGTH OF STAY (in this place) <u>6 WKS</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>823 West Main St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Eleanor</u> <u>Spencer</u> <u>Keyser</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9-</u> <u>10-</u> <u>19 55</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>5-17-1866</u>
9. AGE last birthday: <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>THOMAS J. WILLIS</u>		14. MOTHER'S MAIDEN NAME: <u>MARY CHAPLIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No.: <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>MRS Mike Disharoom. SAME</u>			

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
9040 Immediate cause (a) <u>Broncho-pneumonia</u> DUE TO Antecedent cause(s) (b) <u>Fractured right hip</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				3 days  17 days.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u> )		21c. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7</u> <u>25</u> <u>55</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell at home.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>E. L. Rye</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>9-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>9/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>CHESTER CEMETERY</u>	
DATE REC'D BY LOCAL <u>9-12-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Hill &amp; Johnson Co.</u>	
				LOCATION (City, town, or county) <u>CHESTERTOWN, Md</u> ADDRESS <u>Salisbury, Md</u> <u>Norman T. Baker</u>	

BUREAU V. 2

SEP 14 1955

RECEIVED

9185

## CERTIFICATE OF DEATH

10265

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>12 TOWN Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>12 TOWN Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>82 Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>135 Truitt St.</b>			
<b>3. NAME OF DECEASED</b> (First) <b>MARY</b> (Middle) <b>ELIZABETH</b> (Last) <b>LECATES</b>				<b>4. DATE OF DEATH</b> (Month) <b>Sept.</b> (Day) <b>30</b> (Year) <b>19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Jan. 6, 1885</b>	<b>9. AGE last birthday</b> <b>70</b> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Sussex Co. Delaware</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John Davis</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Kate (unk)</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Vernon Ross (Daughter) 135 Truitt St. Salisbury, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1</b> IMMEDIATE CAUSE (A) <b>Coronary Occlusion</b>						<b>Sudden</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 9/29, 1955, to 9/30, 1955, that I last saw the deceased alive on 9/30, 1955, and that death occurred at 10:40 AM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Frederic R. Grammer</i>		<b>DATE THEREOF</b> <b>Oct. 2, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>24. REC'D BY REGISTRAR</b> <b>Oct. 11, 1955</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>ADDRESS</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>	

VS A15C 1-55 10M

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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**INSTRUCTIONS**

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9186

# CERTIFICATE OF DEATH

09203

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
12 <u>Salisbury.</u>		<u>Most of life</u>		12 <u>Salisbury</u>		1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>At home - 615 Lake Street</u>				<u>615 Lake Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Samuel Leonard</u>				<u>9 - 11 19 55</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Male</u>		<u>A.A.</u>		<u>Widowed</u>		<u>About 1894</u>	
<b>9. AGE last birthday</b>		<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>			
<u>About 61 yrs.</u>		Months Days		Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<u>Janitor</u>				<u>High Salisbury School</u>		<u>Wetipquin, Wicomico Co. Md.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<u>USA</u>			
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Samuel Leonard</u>				<u>Emily Morris</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>No</u>				<u>220-32-8613</u>		<u>James Leonard, 615 Lake St. Salisbury, Md.</u>	
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Heart Disease</u>							
DUE TO ANTECEDENT CAUSE(S) (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE</b> (Home, farm, lecture, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>6:45 p.m., 19 55</u> <b>to</b> <u>11:45 p.m., 19 55</u> <b>that I last saw the deceased</b> <b>alive on</b> <u>11:45 p.m., 19 55</u> <b>and that death occurred at</b> <u>5:44 M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)			
<u>Thurnell, M.D.</u>				<u>652 Wicomico St., Salisbury, Md. 13 Sept 55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
<u>Burial</u>				<u>9-14-55</u>		<u>Green Acres Memorial Park</u>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<u>Sept. 15, 1955</u>				<u>Mary H. Holloway</u>		<u>Mary A. Stewart</u>	
<b>DATE</b>				<b>ADDRESS</b>		<b>ADDRESS</b>	
				<u>Salisbury, Md.</u>		<u>324 E. Church St. Salisbury, Md.</u>	



THIS IS TO CERTIFY THAT THE FOLLOWING IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE ATTORNEY GENERAL, DEPARTMENT OF JUSTICE, ON SEPTEMBER 15, 1955.

# CERTIFICATE OF DEATH

STATE OF MARYLAND, DEPARTMENT OF HEALTH - BALTIMORE, 18

1955

1. NAME AND OFFICE ADDRESS OF REGISTRAR

NAME: [illegible] OFFICE: [illegible]

2. PLACE OF DEATH

[illegible]

3. MANNER OF DEATH

[illegible]

[illegible]

4. DATE OF DEATH

5. SEX AND AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. SIGNATURE OF REGISTRAR

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF CORONER

12. SIGNATURE OF JURY

13. SIGNATURE OF COURT

14. SIGNATURE OF CLERK

15. SIGNATURE OF [illegible]

16. SIGNATURE OF [illegible]

17. SIGNATURE OF [illegible]

18. SIGNATURE OF [illegible]

19. SIGNATURE OF [illegible]

BUREAU V. 8

SEP 15 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9187 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				09204 Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				No. 332	
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>in Hospital</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Rural Pocomoke - 18X2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>			STREET ADDRESS (If rural, give location) <u>✓</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH:		
(First) <u>Leno</u> (Middle) <u>Long</u> (Last) <u>Long</u>			(Month) <u>Sept</u> (Day) <u>26</u> (Year) <u>1955</u>		
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	
8. DATE OF BIRTH: <u>June 8, 1875</u>		9. AGE last birthday: <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>			13. FATHER'S NAME: <u>Joseph Dickerson</u>		
14. MOTHER'S MAIDEN NAME: <u>Henrietta Collins</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>		
16. SOCIAL SECURITY No.: <u>None</u>			17. INFORMANT & ADDRESS: <u>Minnie Miller - Pocomoke City, Md.</u>		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.1 Immediate cause (a) <u>Died in hospital - Acute coronary occlusion</u>					
Antecedent cause(s) (b) <u>Following operation for fracture of</u>					
Diseases or conditions, if any, giving rise to the above cause (c) <u>right hip - Had fall Sept 16, 55</u>					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>8</u>					19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Home</u>		21c. (City or town) (County) (State) <u>Pocomoke R.F.D Somerset 19 Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>Sept 16, 55</u> A M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR: <u>Had a fall in home -</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Rt. Johnson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Sept 28, 55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10-15-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Ball Hill Cem</u>	
LOCATION (City, town, or county) (State): <u>Pocomoke, Md.</u>		24. FUNERAL DIRECTOR: <u>Edgar Reshaker</u>		ADDRESS: <u>New Church</u>	
DATE REC'D BY LOCAL REG. <u>9-29-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Hollaway</u>			

MARYLAND DEPARTMENT OF HEALTH

For use only in connection with the Maryland Death Certificate. It is not to be used for any other purpose. It is to be filled out by the physician or other person authorized to sign the certificate.

1. PLACE OF BIRTH		2. NAME OF DECEASED (Type in full)		3. SEX		4. COLOR OR RACE		5. MARRIAGE STATUS		6. DATE OF BIRTH		7. PLACE OF BIRTH		8. DATE OF DEATH	
CITY, VILLAGE, TOWN, OR RURAL (On the map)		CITY, VILLAGE, TOWN, OR RURAL (On the map)		MARRIED, SINGLE, WIDOWED, DIVORCED		MARRIED, SINGLE, WIDOWED, DIVORCED		MARRIED, SINGLE, WIDOWED, DIVORCED		MARRIED, SINGLE, WIDOWED, DIVORCED		MARRIED, SINGLE, WIDOWED, DIVORCED		MARRIED, SINGLE, WIDOWED, DIVORCED	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS	
10. FATHER'S NAME		11. MOTHER'S MAIDEN NAME		12. Was deceased ever in the armed forces? (If not, give year of service)		13. Was deceased ever in the armed forces? (If not, give year of service)		14. Was deceased ever in the armed forces? (If not, give year of service)		15. Was deceased ever in the armed forces? (If not, give year of service)		16. Was deceased ever in the armed forces? (If not, give year of service)		17. Was deceased ever in the armed forces? (If not, give year of service)	
18. MEDICAL CERTIFICATION		19. MEDICAL CERTIFICATION		20. MEDICAL CERTIFICATION		21. MEDICAL CERTIFICATION		22. MEDICAL CERTIFICATION		23. MEDICAL CERTIFICATION		24. MEDICAL CERTIFICATION		25. MEDICAL CERTIFICATION	
26. MEDICAL CERTIFICATION		27. MEDICAL CERTIFICATION		28. MEDICAL CERTIFICATION		29. MEDICAL CERTIFICATION		30. MEDICAL CERTIFICATION		31. MEDICAL CERTIFICATION		32. MEDICAL CERTIFICATION		33. MEDICAL CERTIFICATION	
34. MEDICAL CERTIFICATION		35. MEDICAL CERTIFICATION		36. MEDICAL CERTIFICATION		37. MEDICAL CERTIFICATION		38. MEDICAL CERTIFICATION		39. MEDICAL CERTIFICATION		40. MEDICAL CERTIFICATION		41. MEDICAL CERTIFICATION	
42. MEDICAL CERTIFICATION		43. MEDICAL CERTIFICATION		44. MEDICAL CERTIFICATION		45. MEDICAL CERTIFICATION		46. MEDICAL CERTIFICATION		47. MEDICAL CERTIFICATION		48. MEDICAL CERTIFICATION		49. MEDICAL CERTIFICATION	
50. MEDICAL CERTIFICATION		51. MEDICAL CERTIFICATION		52. MEDICAL CERTIFICATION		53. MEDICAL CERTIFICATION		54. MEDICAL CERTIFICATION		55. MEDICAL CERTIFICATION		56. MEDICAL CERTIFICATION		57. MEDICAL CERTIFICATION	
58. MEDICAL CERTIFICATION		59. MEDICAL CERTIFICATION		60. MEDICAL CERTIFICATION		61. MEDICAL CERTIFICATION		62. MEDICAL CERTIFICATION		63. MEDICAL CERTIFICATION		64. MEDICAL CERTIFICATION		65. MEDICAL CERTIFICATION	
66. MEDICAL CERTIFICATION		67. MEDICAL CERTIFICATION		68. MEDICAL CERTIFICATION		69. MEDICAL CERTIFICATION		70. MEDICAL CERTIFICATION		71. MEDICAL CERTIFICATION		72. MEDICAL CERTIFICATION		73. MEDICAL CERTIFICATION	
74. MEDICAL CERTIFICATION		75. MEDICAL CERTIFICATION		76. MEDICAL CERTIFICATION		77. MEDICAL CERTIFICATION		78. MEDICAL CERTIFICATION		79. MEDICAL CERTIFICATION		80. MEDICAL CERTIFICATION		81. MEDICAL CERTIFICATION	
82. MEDICAL CERTIFICATION		83. MEDICAL CERTIFICATION		84. MEDICAL CERTIFICATION		85. MEDICAL CERTIFICATION		86. MEDICAL CERTIFICATION		87. MEDICAL CERTIFICATION		88. MEDICAL CERTIFICATION		89. MEDICAL CERTIFICATION	
90. MEDICAL CERTIFICATION		91. MEDICAL CERTIFICATION		92. MEDICAL CERTIFICATION		93. MEDICAL CERTIFICATION		94. MEDICAL CERTIFICATION		95. MEDICAL CERTIFICATION		96. MEDICAL CERTIFICATION		97. MEDICAL CERTIFICATION	
98. MEDICAL CERTIFICATION		99. MEDICAL CERTIFICATION		100. MEDICAL CERTIFICATION		101. MEDICAL CERTIFICATION		102. MEDICAL CERTIFICATION		103. MEDICAL CERTIFICATION		104. MEDICAL CERTIFICATION		105. MEDICAL CERTIFICATION	

RECEIVED

OCT 3 1955

BUREAU V. S.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9188

## CERTIFICATE OF DEATH

09205

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>221 Broad St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) (Middle) (Last) <u>Lu F Fman</u>				(Month) (Day) (Year) <u>September 11 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>		<u>September 11 1925</u>	<u>30</u> yrs.	Months Days	Hours Min.	<u>1 55</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>none</u>		<u>none</u>		<u>Maryland</u>		<u>U.S.A</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Unknown</u>				<u>Daisy Godwin</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>none</u>		<u>none</u>		<u>Daisy Lu F Fman Bapedst.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE</b> (A) <u>Premature birth - neonatal</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 hrs</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>death - immaturity and</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO</b> (C) <u>delectasia, Physiological</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Sept 11, 1955</u> <b>to</b> <u>Sept 11, 1955</u> <b>that I last saw the deceased</b> <u>alive on</u> <u>11 Sept</u> <b>19</b> <u>55</u> <b>and that death occurred at</b> <u>7:45 P.</u> <b>M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>			
<u>Robert W. Sauerberson</u>		<u>M.D. 926 N. Division St Salisbury</u>		<u>9/12/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>cremation</u>		<u>9/12/55</u>		<u>Peninsula General Hospital</u>		<u>Salisbury Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>9-12-55</u>		<u>Mary W. Holloway</u>		<u>Peninsula General Hospital</u>			

2095213280

# CERTIFICATE OF DEATH

10-10-55

Form 10-10-55

1. NAME OF DECEASED (Print or Write)

2. SEX  
3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH (Print or Write)

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESS

BUREAU V. S.

SEP 14 1955

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RECEIVED

THIS CERTIFICATE OF DEATH IS A STATUTORY REQUIREMENT OF THE MARYLAND STATE DEPARTMENT OF HEALTH. IT IS TO BE COMPLETED BY THE PHYSICIAN WHO ATTENDS THE DECEASED OR BY THE REGISTRAR OF DEATHS. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IT IS TO BE MAINTAINED IN THE OFFICE OF THE REGISTRAR OF DEATHS FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST.



1

INSTRUCTIONS

I

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9189

## CERTIFICATE OF DEATH

09206

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b> COUNTY <b>Wicomico</b>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <b>Salisbury</b>		<b>10 yrs.</b>		TOWN <b>Salisbury</b>		<b>12</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>At home - 608 W. Isabella St.</b>				STREET ADDRESS (If rural give location) <b>608 W. Isabella Street</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Charles Wilmore Mason</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>9 - 8 - 19 55</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>A.A.</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>		<b>8. DATE OF BIRTH</b> <b>8-4-1908</b>	
<b>9. AGE last birthday</b> <b>47 yrs.</b>		<b>10. KIND OF BUSINESS OR INDUSTRY</b> <b>Grocery Store</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Salughter Neck, Delaware</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Laborer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Grocery Store</b>			
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b> <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>217-12-4688</b>			
<b>17. INFORMANT &amp; ADDRESS</b> <b>608 W. Isabella St.</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>IMMEDIATE CAUSE (A)</b> <b>442X Hypertensive Cardiovascular Renal Disease</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>undetermined</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Malignant Hypertension</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>undetermined</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>19a. DATE OF OPERATION</b> <b>0</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second)</b>	
<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>		<b>21g. HOW DID INJURY OCCUR?</b>		<b>21h. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from 8 Sept, 1955, to 8 Sept, 1955, that I last saw the deceased alive on 8 Sept, 1955, and that death occurred at 6:00 M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>E. H. Harnell</b>				<b>DATE SIGNED</b> <b>9 Sept 55</b>			
<b>ADDRESS (Street, city, town, state)</b> <b>652 W. Main St., Salisbury, Md.</b>				<b>ADDRESS (Street, city, town, state)</b> <b>324 E. Church St., Salisbury, Md.</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>9-11-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Slaughter Neck Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Slaughter Neck, Delaware</b>	
<b>24. REC'D BY REGISTRAR</b> <b>SEP 13 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Mary A. Stewart</b>		<b>ADDRESS</b> <b>324 E. Church St., Salisbury, Md.</b>	



10308

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

# CERTIFICATE OF DEATH

Reg. Dist. No.

A. FINAL MEDICAL HISTORY OF DECEASED

1. NAME OF DECEASED: Mrs. Mary Ann

2. SEX: Female

3. AGE: 10 yrs.

4. OCCUPATION: School

5. PLACE OF BIRTH: Baltimore, Md.

6. DATE OF BIRTH: 10-1-1918

7. PLACE OF DEATH: 308 W. Lomb St.

8. DATE OF DEATH: 10-1-1928

9. TIME OF DEATH: 11:00 A.M.

10. CAUSE OF DEATH: Unknown

11. MANNER OF DEATH: Natural

12. SIGNATURE OF PHYSICIAN: J. Edgar

13. SIGNATURE OF REGISTRAR: J. Edgar

14. SIGNATURE OF WITNESSES: J. Edgar

15. SIGNATURE OF DECEASED: J. Edgar

16. SIGNATURE OF DECEASED: J. Edgar

17. SIGNATURE OF DECEASED: J. Edgar

18. SIGNATURE OF DECEASED: J. Edgar

19. SIGNATURE OF DECEASED: J. Edgar

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55. SIGNATURE OF DECEASED: J. Edgar

1. NAME OF DECEASED: Mrs. Mary Ann

2. SEX: Female

3. AGE: 10 yrs.

4. OCCUPATION: School

5. PLACE OF BIRTH: Baltimore, Md.

6. DATE OF BIRTH: 10-1-1918

7. PLACE OF DEATH: 308 W. Lomb St.

8. DATE OF DEATH: 10-1-1928

9. TIME OF DEATH: 11:00 A.M.

10. CAUSE OF DEATH: Unknown

11. MANNER OF DEATH: Natural

12. SIGNATURE OF PHYSICIAN: J. Edgar

13. SIGNATURE OF REGISTRAR: J. Edgar

14. SIGNATURE OF WITNESSES: J. Edgar

15. SIGNATURE OF DECEASED: J. Edgar

16. SIGNATURE OF DECEASED: J. Edgar

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508 W. Lomb St. Baltimore, Md.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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9190

## CERTIFICATE OF DEATH

Dr. Wm Smith

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Salisbury</b>				TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
<b>806 Cooper St</b>				<b>806 Cooper St.</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>SADIE</b>		(Middle) <b>GERTRUDE</b>		(Last) <b>MATTHEWS</b>			
<b>Female</b>		<b>White</b>		<b>Sept 29, 1883</b>		<b>Sept. 9th 1955</b>	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>House Work</b>		<b>at Home</b>		<b>Virginia</b>		<b>USA</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Severn J. Evans</b>				<b>No Record</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>			
<b>No</b>							
<b>17. INFORMANT &amp; ADDRESS</b>							
<b>Mrs. Riley D. Green (Daughter) 806 Cooper St. Salisbury, Maryland</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <b>Cardiac Insufficiency</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>Diabetes, Embolism</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Arteriosclerosis</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan 1, 1955, to 9-9, 1955, that I last saw the deceased alive on 9/9, 1955, and that death occurred at 1:30A M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Wm Smith</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>N. Division St Salisbury, Md.</b>		<b>DATE SIGNED</b> <b>Sept 10 1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>Sept. 12, 1955</b>		<b>Wicomico Memorial Park</b>		<b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>SEP 13 1955</b>		<i>Mary H. Holloway</i>		<b>HOLLOWAY &amp; COMPANY</b>		<b>SALISBURY MARYLAND</b>	

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09209

9191

## CERTIFICATE OF DEATH

Dr. Burton

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b> COUNTY <b>Wicomico</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		TOWN <b>Salisbury</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1032 East Main St</b>		STREET ADDRESS <b>1032 East Main St.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		TOWN <b>Salisbury</b>	
<b>3. NAME OF DECEASED</b> (First) <b>WALTER</b> (Middle) <b>JOSEPH</b> (Last) <b>MICKLETHWAITE</b>				<b>4. DATE OF DEATH</b> (Month) <b>Sept.</b> (Day) <b>2 nd</b> (Year) <b>19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>April 4th 1874</b>	<b>9. AGE last birthday</b> <b>81</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>28</b>	<b>IF UNDER 24 HRS.</b> Hours <b>2</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Hatchery Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Walter Joseph Micklethwaite</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Ramsey</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk</b> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Beverly Micklethwaite, Salisbury, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE</b> (A) <b>Myocardial infarction</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b>			
<b>ANTECEDENT CAUSE(S)</b> DUE TO <b>Coronary artery atherosclerosis</b>				<b>Years</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO <b>Generalized atherosclerosis; hypertension</b>				<b>Years</b>			
<b>STATING UNDERLYING CAUSE LAST.</b> (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 8/23/1955, to 9/1/1955, that I last saw the deceased alive on 8/23/1955, and that death occurred at 4:00A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS</b> (Street, city, town, state) <b>M.D. Maryland Ave. Salisbury, Maryland</b>			
<b>DATE SIGNED</b> <b>Sept. 2, 1955</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Sept. 3, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Riverton Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Near Sharptown, Maryland</b>	
<b>24. REGD BY REGISTRAR</b> <b>Sept. 6, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b> <b>SALISBURY MARYLAND</b>			

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Entered Postoffice at New York, N.Y., May 1, 1907.

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Voltaire, Jean-Pierre

TABLE 3. *Continued*

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9211

## CERTIFICATE OF DEATH

09208

Reg. Dist. No. 336

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (if outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Delmar</b>		<b>60 yrs</b>		TOWN <b>Delmar</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>State Street</b>				<b>State Street</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Annie</b> (Middle) <b>L.</b> (Last) <b>Nichols</b>				(Month) <b>Sept.</b> (Day) <b>20</b> (Year) <b>19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>8-23- 1875</b>	<b>80</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>At Home</b>		<b>Home</b>		<b>Felton, Del.</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Levin G. Beauchamp</b>				<b>Julia Phillips</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>		<b>None</b>		<b>Howard Nichols, Delmar, Del.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				ACUTE DILATATION OF HEART			
ANTECEDENT CAUSE(S) DUE TO				CHRONIC MYOCARDITIS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				SATURATED SCLEROSIS			
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				30 min.			
				5 hr.			
				8 hr.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept. 10, 1955</b> to <b>Sept. 20, 1955</b> , that I last saw the deceased alive on <b>Sept. 10, 1955</b> , and that death occurred at <b>4:40 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>L. H. Nichols</b> M.D.				ADDRESS (Street, city, town, state) <b>Delmar, Del.</b>		DATE SIGNED <b>Sept. 22/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>9-22-55</b>		<b>Mt. Olive Cemetery</b>		<b>Delmar, Del.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>Sept 23, 1955</b>		<b>Harry E. Hudson</b>		<b>W. S. Marvel</b>		<b>Delmar, Del.</b>	



# CERTIFICATE OF DEATH

0001

Rev. Oct. 1955

1. DECEASED PERSON'S NAME (Last, First, Middle)

2. PLACE OF DEATH

3. SEX AND AGE AT DEATH

4. RACE

5. OCCUPATION

6. MARITAL STATUS

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH (Immediate)

10. CAUSE OF DEATH (Underlying)

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. PLACE OF BIRTH

16. DATE OF BIRTH

17. PLACE OF DEATH (Detailed)

18. SEX

19. AGE

20. RACE

21. OCCUPATION

22. MANNER OF DEATH

23. SIGNATURE OF PHYSICIAN

24. SIGNATURE OF REGISTRAR

25. SIGNATURE OF WITNESSES

26. SIGNATURE OF WITNESSES

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BUREAU V. 8

SEP 23 1955

RECEIVED

1. DECEASED PERSON'S NAME (Last, First, Middle)  
2. PLACE OF DEATH  
3. SEX AND AGE AT DEATH  
4. RACE  
5. OCCUPATION  
6. MARITAL STATUS  
7. DATE OF DEATH  
8. TIME OF DEATH  
9. CAUSE OF DEATH (Immediate)  
10. CAUSE OF DEATH (Underlying)  
11. MANNER OF DEATH  
12. SIGNATURE OF PHYSICIAN  
13. SIGNATURE OF REGISTRAR  
14. SIGNATURE OF WITNESSES  
15. PLACE OF BIRTH  
16. DATE OF BIRTH  
17. PLACE OF DEATH (Detailed)  
18. SEX  
19. AGE  
20. RACE  
21. OCCUPATION  
22. MANNER OF DEATH  
23. SIGNATURE OF PHYSICIAN  
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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

9192

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

09210

Dr. Harry Mattox

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>12 TOWN Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>12 TOWN Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 800 Cooper St</b>				STREET ADDRESS (If rural give location) <b>1 800 Cooper St.</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>HERMAN JAMES OWENS</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Sept. 14 th 19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>July 5, 1888</b>		<b>9. AGE last birthday</b> <b>67 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>3</b> Days <b>9</b> Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Engineer (Victor Lynn Lines)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Dames Quarter, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>James Owens</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Priscilla White</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Pearl M. Owens (Wife) 800 Cooper St. Salisbury, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b> <b>acute coronary occlusion</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>immediate</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>0</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 9/14, 1955, to 9/14, 1955, that I last saw the deceased alive on 9/14, 1955, and that death occurred at 2:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Harry Mattox</b>		<b>M.D.</b>		<b>ADDRESS</b> (Street, city, town, state) <b>Camden Ave. Salisbury, Maryland</b>		<b>DATE SIGNED</b> <b>Sept. 16 1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Sept 17, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Wicomico Memorial Park</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			
<b>DATE</b> <b>Sept. 19, 1955</b>							

# CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		SEX Male		DATE OF BIRTH May 5, 1928		PLACE OF BIRTH Jackson, Mississippi	
RACE White		MARRIAGE Single		OCCUPATION None		RESIDENCE Room 10, 505 Commerce St., Memphis, Tennessee	
DATE OF DEATH April 4, 1968		PLACE OF DEATH Memphis, Tennessee		CAUSE OF DEATH Gunshot wound		MANNER OF DEATH Homicide	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	

BUREAU V. S.

SEP 28 1955

RECEIVED

U.S. GOVERNMENT PRINTING OFFICE: 1955

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the registrar of vital statistics of the state or territory in which the death occurred. It is also to be filed in the office of the registrar of vital statistics of the United States. The certificate is to be filled out in duplicate. One copy is to be filed in the office of the registrar of vital statistics of the state or territory in which the death occurred. The other copy is to be filed in the office of the registrar of vital statistics of the United States. The certificate is to be filled out in duplicate. One copy is to be filed in the office of the registrar of vital statistics of the state or territory in which the death occurred. The other copy is to be filed in the office of the registrar of vital statistics of the United States.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

09211

Reg. Dist. No. ....

9193

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>MARYLAND</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Salisbury</b>				TOWN <b>Eden</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>P.G. Hospt.</b>				STREET ADDRESS (If rural give location) <b>R.D. #2.</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Annie Madora Phillips</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Sept. 27. 1955.</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widow</b>	<b>8. DATE OF BIRTH</b> <b>July 27, 1882.</b>	<b>9. AGE last birthday</b> <b>73</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if <b>house work</b> )		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Wicomico County, Maryland.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Henry Rayall</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Theodosia Chatham</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Cecil H. Phillips (Son)</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b> <b>R.D. # 2. Salisbury, Md.</b>			
<b>442X</b> IMMEDIATE CAUSE (A) <b>Cardiovascular renal disease</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <b>Salisbury Wicomico Maryland</b>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 9/12, 1922, to 9/27, 1955, that I last saw the deceased alive on 9/27, 1955, and that death occurred at 11.30 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Theresa Insley</i>				<b>ADDRESS</b> (Street, city, town, state) <b>M.D. 116 E. Main St., Salisbury, Md. 101-55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Oct. 1. 55.</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Trinity Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Near Allen, Maryland.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Oct. 5, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Holloway &amp; Co. Salisbury, Maryland.</b>			





**1**

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09212

# CERTIFICATE OF DEATH

Dr. Burton

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTRY <b>Wicomtto</b>		STATE <b>Maryland</b> COUNTY <b>Wicomico</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		TOWN <b>Salisbury</b>	
CITY OR TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		STREET ADDRESS <b>107 Center St</b>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Riverside Nursing Home</b>							
<b>3. NAME OF DECEASED</b> (First) <b>VENIE</b> (Middle) <b>ROSA</b> (Last) <b>PUSEY</b>				<b>4. DATE OF DEATH</b> (Month) <b>Sept.</b> (Day) <b>9th</b> (Year) <b>19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Aug. 21, 1903</b>	<b>9. AGE last birthday</b> <b>52</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>	<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Work, (Retired) at Home</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Laurel Delaware</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13. FATHER'S NAME</b> <b>Ebenezer White</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Rosa Gordy</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. J. Sidney White (Brother) 306 Monticello Ave. Salisbury, Maryland</b>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>170X</b> IMMEDIATE CAUSE (A) <b>Generalized carcinomatosis</b>				<b>2 years</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Carcinoma of R. breast</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>					
<b>22. I hereby certify that I attended the deceased from 4/18/55, 1955, to 9/7/55, 1955, that I last saw the deceased alive on 9/7/55, 1955, and that death occurred at 10:15A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS</b> (Street, city, town, state) <b>Maryland Ave. Salisbury, Md.</b>		<b>DATE SIGNED</b> <b>Sept. 9 1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Sept. 11, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Wicomico Memorial Park</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>SEP 13 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary W. Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>		<b>ADDRESS</b> <b>SALISBURY MARYLAND</b>	



RECEIVED

RECEIVED  
U.S. DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
WASHINGTON, D.C.  
SEP 13 1955

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

NAME (Last, first, middle) RIVERDALE MURKIN ROSE		SEX FEMALE		RACE WHITE		AGE 22, 1903		DATE OF DEATH SEP 13 1955		PLACE OF DEATH 1005 CENTER ST BALTIMORE	
RESIDENCE HOUSE 1005 (KENTON) ST HOME		BIRTHPLACE BALTIMORE		MARRIAGE MARRIED		EDUCATION HIGH SCHOOL		OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		CERTIFICATE NO. 1005		REGISTRATION NO. 1005		DATE OF REGISTRATION SEP 13 1955		SIGNATURE OF REGISTRAR [Signature]		OFFICIAL SEAL [Seal]	

BUREAU V. 2

SEP 13 1955

RECEIVED

U.S. DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
WASHINGTON, D.C.  
SEP 13 1955

## CERTIFICATE OF DEATH

Reg. Dist. No.....

9195

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>20 yrs.</u>		CITY OR TOWN <u>Salisbury</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>637 S. Division St.</u>				STREET ADDRESS <u>637 S. Division St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>MARY Catherine RIGGIN</u>				<u>9 20 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Mar. 14, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>John W. Riffin</u>				14. MOTHER'S MAIDEN NAME <u>Martha Wimbrow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Mrs. Annie Godfrey - Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
592X IMMEDIATE CAUSE (A) <u>Left cerebral thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arterio sclerosis &amp; hypertension</u>				<u>Yes</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic glomerular nephritis</u>				<u>Yes</u>			
260X OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Uremia - Diabetes Mellitus</u>				<u>Yes</u>			
19a. DATE OF OPERATION <u>9/20/55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/11</u> , 19 <u>55</u> , to <u>9/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>55</u> , and that death occurred at <u>11:10 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>M.D. 211 Maryland Ave. Salisbury Md.</u>		DATE SIGNED <u>9/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/23/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>The Hill &amp; Johnson Co. Salisbury, Md.</u>	
DATE <u>Sept. 26, 1955</u>							

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1951

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

# CERTIFICATE OF DEATH

7195

PLACE OF DEATH		City of Baltimore	
County of Baltimore		State of Maryland	
Date of Death		May 15, 1951	
Time of Death		10:30 A.M.	
Cause of Death		Heart Disease	
Age		65	
Sex		Male	
Race		White	
Occupation		Grocery	
Residence		1234 E. Baltimore St.	
Marital Status		Married	
Signature of Physician		John F. Ryan	
Signature of Coroner		John F. Ryan	
Signature of Registrar		John F. Ryan	

BUREAU V. S.

SEP 26 1955

RECEIVED

The Hill & Johnson Co. Baltimore, Md.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09214

9196

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12</u> TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>Unk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - First Street</u>				STREET ADDRESS (If rural give location) <u>First Street</u>		<u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Walter Roberts</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>9 - 10 - 19 55</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>A.A.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Unk</u>	<b>8. DATE OF BIRTH</b> <u>1913</u>	<b>9. AGE last birthday</b> <u>42</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Hod Carrier</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Dames Quarter, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Unk</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UNK</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>219-34-3483</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Salisbury, Md.</u> <u>Wicomico County Board of Welfare</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>442X</u> IMMEDIATE CAUSE (A) <u>Cardiovascular Renal Disease</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<b>18. MEDICAL CERTIFICATION</b> <u>Cardiovascular Renal Disease</u> INTERVAL BETWEEN ONSET AND DEATH			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> et work <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> et work <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Oct 15 1954</u> , to <u>Sept 12 1955</u> , that I last saw the deceased alive on <u>Sept 10, 1955</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above. <b>SIGNATURE</b> <u>W. Purnell</u> <b>ADDRESS</b> (Street, city, town, state) <u>612 W Main St., Salisbury Md</u> <b>DATE SIGNED</b> <u>12 Sept 55</u> M. D. <u>612 W Main St., Salisbury Md</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Bucial</u>		<b>DATE THEREOF</b> <u>9-15-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Houston Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Salisbury, Wicomico Co. Md.</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>Sept. 19, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Mary A. Stewart</u>		<b>ADDRESS</b> <u>324 E. Church St. Salisbury, Md.</u>	

00519

WISCONSIN STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

# CERTIFICATE OF DEATH

1955

Reg. No. 100-100

1. FULL NAME OF DECEASED

John Edward Smith

DATE OF BIRTH

1910-01-01

Place of Birth

Sex

Male

Street Address

At Home - 1234 Street

City, State, and Zip

Waterbury, Conn.

DATE OF DEATH

1955

10-10-55

10-10-55

10-10-55

Place of Death

At Home

Signature of Doctor

MD

MD

BUREAU V. S.

SEP 19 1955

RECEIVED

Waterbury, Conn.

Waterbury, Conn.

10-10-55

10-10-55

INSTRUCTIONS



9212

09215

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:				
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR				
X TOWN <u>Bivalve</u>		<u>life</u>		TOWN <u>Bivalve</u> X				
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS (If rural, give location) <u>1</u>				
3. NAME OF DECEASED: (First) <u>Joyce</u>		(Middle) <u>Anne</u>		(Last) <u>Smith</u>		4. DATE OF DEATH (Month) <u>9</u> (Day) <u>17</u> (Year) <u>19 55</u>		
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>O</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>infant</u>	8. DATE OF BIRTH: <u>8-9-55</u>	9. AGE last birthday: <u>1</u> yrs. <u>7</u> Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 1 YEAR			IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME: <u>John Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Smith</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>John Smith, Bivalve, Md.</u>				
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:								
<u>9240</u> Immediate cause (a) <u>Mechanical asphyxiation</u> DUE TO Antecedent cause(s) (b) <u>—</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>—</u>							<u>Sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19a. DATE OF OPERATION: <u>9-17-55</u>		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) <u>Bivalve</u> (County) <u>Wicomico</u> (State) <u>Maryland</u>				
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9-17-55 7A M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Sleeping on abdomen and smothered.</u>				
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
SIGNATURE <u>Earl L. Roy</u>		M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>9-17-55</u>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>9/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Gesterville Cemetery</u>		LOCATION (City, town, or county) <u>Gesterville, Md.</u> (State) <u>Md.</u>		
DATE REC'D BY LOCAL REG. <u>9-21-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>C. H. Wessou</u>		ADDRESS <u>Bivalve, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53



RECEIVED

SEP 23 1955

BUREAU V. 8

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09216

9197

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salbyville</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hosp.</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Baby Boy Snyder</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>9-19-55</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>9-18-55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>2</u> <u>40</u>	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Theodore Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Violet Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
776X IMMEDIATE CAUSE (A) <u>Prematurity</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>9/18</u>, 19<u>55</u>, to <u>9/19</u>, 19<u>55</u>, that I last saw the deceased alive on <u>9/19</u>, 19<u>55</u>, and that death occurred at <u>5:25</u> A.M. from the causes and on the date stated above.</b>							
SIGNATURE <u>William C. Morgan</u> M.D. <u>Salisbury Md</u>				ADDRESS (Street, city, town, state) <u>Peninsula General Hospital, Salisbury, Wicomico Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>9/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Marjorie W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	
DATE <u>9/26/55</u>							

295202200

# CERTIFICATE OF DEATH

File No. 100

LOCAL RESIDENCE (HOUSE OR BUSINESS)

MARYLAND

COUNTY OF BALTIMORE

(City, Town, or Village)

Street

Room

Apartment

Other

Place of Birth

Age

Sex

Marital Status

Occupation

Education

Religion

Previous Illnesses

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Place of Death

Time of Death

Date of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Pathologist

Signature of Forensic Scientist

Signature of Toxicologist

Signature of Anthropologist

Signature of Archaeologist

Signature of Linguist

Signature of Historian

Signature of Philologist

Signature of Philosopher

Signature of Sociologist

Signature of Anthropologist

Signature of Archaeologist

Signature of Linguist

Signature of Historian

Signature of Philologist

Signature of Philosopher

Signature of Sociologist

Signature of Anthropologist

Signature of Archaeologist

Signature of Linguist

Signature of Historian

Signature of Philologist

Signature of Philosopher

Signature of Sociologist

Signature of Anthropologist

Signature of Archaeologist

Signature of Linguist

Signature of Historian

Signature of Philologist

Signature of Philosopher

Signature of Sociologist

Signature of Anthropologist

Signature of Archaeologist

BUREAU V. 2

SEP 22 1955

RECEIVED

BRADY GILMORE

1

INSTRUCTIONS

I

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9198

## CERTIFICATE OF DEATH

09217

Dr. Mattox

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
12 TOWN <b>Salisbury</b>				12 TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>433 Virginia Ave</b>				STREET ADDRESS (If rural give location) <b>433 Virginia Ave.</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>ROBERT</b> (Middle) <b>NELSON</b> (Last) <b>TAYLOR</b>				(Month) <b>Sept.</b> (Day) <b>6th</b> (Year) <b>1955</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>Feb. 27th, 1909</b>	<b>46</b> yrs.	Months <b>6</b>	Days <b>9</b>	Hours <b></b> Min. <b></b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Insurance Salesman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Insurance</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>R.D.# Salisbury, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William S. Taylor</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Julia E. Townsend</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk</b> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Catherine V. Taylor (Wife) 433 Virginia Ave. Salisbury, Maryland</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
420.1 IMMEDIATE CAUSE (A) <b>Acute coronary occlusion</b>						<b>5 minutes</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>previous coronary sclerosis infarction</b>						<b>5 months</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>coronary arteriosclerosis</b>						<b>3 years</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>			<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>		
<b>22. I hereby certify that I attended the deceased from May 1955, to Sept 1955, that I last saw the deceased alive on Sept 6, 1955, and that death occurred at 4:45 PM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Harry Mattox</i>				<b>ADDRESS</b> (Street, city, town, state) <b>Camden Ave. Salisbury, Maryland Sept. 6 1955</b>			
<b>DATE</b> <b>Sept. 8, 1955</b>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Sept. 8, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			

RECEIVED  
 SEP 8 1955  
 BUREAU V. S.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

0517

0508

Dr. J. J. J. J.

Dr. J. J. J. J.

Dr. J. J. J. J.

Dr. J. J. J. J.

Dr. J. J. J. J.

Dr. J. J. J. J.

Dr. J. J. J. J.

Dr. J. J. J. J.

Dr. J. J. J. J.

Dr. J. J. J. J.

Male

White

Married

Feb. 28, 1909

42

6

9

USA

M.D. & S. J. J. J.

Insurance

Insurance

William S. Taylor

William S. Taylor

Mr. William S. Taylor (Wife) - 48  
 4814 Virginia Ave.,  
 Baltimore, Md.

BUREAU V. S.

SEP 8 1955

RECEIVED

Baltimore, Maryland

Married Feb. 28, 1909

WILLIAM S. TAYLOR

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

**CERTIFICATE OF DEATH**

09218

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury, Maryland</b>		LENGTH OF STAY (in this place) <b>11 months</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cambridge, Maryland.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Deer's Head State Hospital</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>William</b>		(Middle) <b>H.</b>		(Last) <b>Warfield</b>		(Month) <b>Sept.</b> (Day) <b>9,</b> (Year) <b>19 55</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>separated</b>	<b>8. DATE OF BIRTH</b> <b>Dec. 24, 1898</b>	<b>9. AGE last birthday</b> <b>56</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>unk</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Cambridge, Maryland.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William Warfield, Sr.</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Henrietta Ward</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>213 18 5351</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Hospital Records</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>331X</b> IMMEDIATE CAUSE (A) <b>Cerebral hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<b>unknown</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>Oct. 26, 1954</b> , to <b>Sept. 9, 1955</b> , that I last saw the deceased alive on <b>Sept. 9, 1955</b> , and that death occurred at <b>6:20p</b> M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>Dr. V. Guerman</b>				<b>ADDRESS</b> (Street, city, town, state) <b>M.D. Deer's Head Hospital, Salisbury, Md.</b>			
				<b>DATE SIGNED</b> <b>9/9/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>9/13/1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Waugh Cemetery</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Cambridge, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>SEP 14 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Herbert M. St. Clair</b>			
				<b>ADDRESS</b> <b>Cambridge, Md.</b>			



1955

# CERTIFICATE OF DEATH

1955

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

DECEASED'S SEX AND AGE AT DEATH

DECEASED'S SEX AND AGE AT DEATH

DECEASED'S SEX AND AGE AT DEATH

DECEASED'S SEX AND AGE AT DEATH

DECEASED'S SEX AND AGE AT DEATH

DECEASED'S SEX AND AGE AT DEATH

DECEASED'S SEX AND AGE AT DEATH

DECEASED'S SEX AND AGE AT DEATH

BUREAU V. B.

SEP 14 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09219

9200  
CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 8 Film 187 9-29-55 et.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>5 wks.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Allen</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Wilmer Nursing Home</b>				STREET ADDRESS (If rural give location) <b>Allen</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>RETTA</b> (Middle) <b>ESTHER</b> (Last) <b>WENDT</b>				(Month) <b>9</b> (Day) <b>20</b> (Year) <b>19 55</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb. 22, 1886</b>	9. AGE last birthday <b>66</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Huffington</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Pollitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT & ADDRESS <b>Mrs. Louise Elzey Allen, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <b>Arteriosclerotic heart disease.</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Cerebro Vascular accident</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>8/13</b> , 19 <b>55</b> , to <b>9/12</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>9/12</b> , 19 <b>55</b> , and that death occurred at <b>9/12</b> , M, from the causes and on the date stated above.							
SIGNATURE <b>A. C. Mitchell</b>				ADDRESS (Street, city, town, state) <b>211 Maryland Salisbury Rd</b>		DATE SIGNED <b>7/22/58</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>9/22/1955</b>		NAME OF CEMETERY OR CREMATORY <b>Allen Cemetery</b>		LOCATION (City, town, or county) (State) <b>Allen Maryland</b>	
24. REC'D BY REGISTRAR <b>Sept. 26, 1955</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co.</b>		ADDRESS <b>Salisbury, MD.</b>	

CERTIFICATE OF DEATH

Form No. 10

1. DECEASED'S NAME (Last, first, middle)

James H. White

James H. White

James H. White

James H. White

White

White

White

White

White

White

White

Feb. 28, 1898

Feb. 28, 1898

Feb. 28, 1898

White

White

White

White

White

White

White

White

BUREAU V. S.

SEP 26 1955

RECEIVED

White

White

White

White

White

The Hall & Johnson Co., Baltimore, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9201

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09220

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>		23.42-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Ella</u>		(Middle) <u>S.</u>		(Last) <u>Willetts</u>		(Month) (Day) (Year) <u>September 27, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Dec 8, 1906</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Accomac Co. Va</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>John Small</u>				14. MOTHER'S MAIDEN NAME: <u>Nora Chandler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs Norman Davis, Pocomoke, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cancer Liver</u>							
ANTECEDENT CAUSE (B) <u>Ascites</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chronic myocarditis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/21</u> , 19 <u>55</u> , to <u>9/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/27</u> , 19 <u>55</u> , and that death occurred at <u>6 P.M.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Wm B Smith</u>		ADDRESS <u>Salisbury Md</u>		DATE SIGNED <u>9/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Sept 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Edgehill</u>		LOCATION (City, town, or county) (State) <u>Accomac Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-27-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>		24. FUNERAL DIRECTOR <u>Robert D. Dyer</u>		ADDRESS <u>Accomac Va</u>	

BUREAU V. S.

SEP 29 1955

RECEIVED

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit. VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

9204  
Dr. Smith

09223  
Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MAYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>12</b> TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>12</b> TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>82</b> <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>417 Priscilla St.</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>AUDREY</b> (Middle) <b>IDA</b> (Last) <b>WILLEY</b>				(Month) <b>SEPT.</b> (Day) <b>19</b> (Year) <b>55</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Jan. 5, 1916</b>	
9. AGE last birthday <b>39</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>14</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Horace Thomas Pennewell</b>				14. MOTHER'S MAIDEN NAME <b>Bessie E. Pusey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>218 -20 -8186</b>		17. INFORMANT & ADDRESS <b>Mr. Roy E. Willey (Husband) 417 Priscilla St. Salisbury, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <b>Broncho pneumonia.</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Edipensoid carcinoma of cervix - Stage IV</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept. 19, 1955</b> , to <b>Sept. 19, 1955</b> , that I last saw the deceased alive on <b>Sept. 19, 1955</b> , and that death occurred at <b>11:00P.</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Stedman W. Smith</b>				ADDRESS (Street, city, town, state) <b>706 Camden Ave. Salisbury, Maryland</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Sept 22, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>Sept. 22, 1955</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			



# CERTIFICATE OF DEATH

1954  
M. Smith

Name of Deceased		M. Smith	
Date of Death		Jan. 15, 1954	
Place of Death		Home	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Age		65	
Sex		Male	
Race		White	
Marital Status		Married	
Date of Marriage		Jan. 10, 1910	
Place of Birth		New York	
Occupation		Teacher	
Signature of Physician		J. H. Jones	
Signature of Registrar		M. Smith	
Date of Registration		Jan. 15, 1954	
Place of Registration		Baltimore, Md.	

BUREAU V. 2

SEP 22 1954

RECEIVED

Dr. Earl Royer (Med Exam)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 09221

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

## I. PLACE OF DEATH:

COUNTY **Wicomico** MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) **Salisbury** LENGTH OF STAY (in this place) **12**HOSPITAL OR INSTITUTION OR STREET ADDRESS **Pen. Gen. Hospital**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Wicomico**CITY (If outside corporate limits write RURAL and give nearest town) **Salisbury**STREET ADDRESS (If rural, give location) **118 East Locust St.**3. NAME OF DECEASED: (First) **JAMES** (Middle) **LITTLETON** (Last) **WILLIAMS**4. DATE OF DEATH (Month) (Day) (Year) **Sept. 22 19 55**5. SEX: **Male** 6. COLOR OR RACE: **White**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **Married** 8. DATE OF BIRTH: **Dec. 16, 1900**9. AGE last birthday: **54** yrs. IF UNDER 1 YEAR: **9** Months **6** Days IF UNDER 24 HRS. **6** Hours **13** Min.10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) **Truck Driver**10b. KIND OF BUSINESS OR INDUSTRY: **Moving and Storage Co.**11. BIRTHPLACE (State or foreign country): **Salisbury, Maryland**12. CITIZEN OF WHAT COUNTRY? **USA**

## 13. FATHER'S NAME:

**John Littleton Williams**

## 14. MOTHER'S MAIDEN NAME:

**Millie Horner**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) **Unk** (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

**Mrs. Reba R. Williams (Wife) 118 East Locust St. Salisbury, Maryland**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

**420.1**  
**Immediate cause**(a) **Coronary occlusion**  
DUE TO**Antecedent cause(s)**Diseases or conditions, if any, giving rise to the above cause stating underlying cause last  
(b) **DUE TO**  
(c)INTERVAL BETWEEN ONSET AND DEATH  
**Sudden**

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY **M.**21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

*Earl Royer*CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
DEPUTY MEDICAL EXAMINER ☒ **Sept. 22 1955**  
ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF **Sept. 25, 1955**NAME OF CEMETERY OR CREMATORY **Wicomico Memorial Park**LOCATION (City, town, or county) (State) **Salisbury, Maryland**DATE RECD BY LOCAL REG. **23-55**REGISTRAR'S SIGNATURE *Mary W. Holloway*

24. FUNERAL DIRECTOR

**HOLLOWAY & COMPANY SALISBURY MARYLAND**

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1932

BUREAU V. S.

SEP 26 1932

RECEIVED

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9213

**CERTIFICATE OF DEATH**

09224

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>		LENGTH OF STAY (in this place) <u>80 Yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main St.,</u>				STREET ADDRESS (If rural give location) <u>Main St.,</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>CORA</u> (Middle) <u>VERLIN</u> (Last) <u>WILSON</u>				(Month) <u>9</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 25, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horatio Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Sally Jane Hastings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or or.) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-34-0840</u>		17. INFORMANT & ADDRESS <u>Dr. Thomas N. Wilson, Baltimore, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
1. IMMEDIATE CAUSE (A) <u>420.0</u>						INTERVAL BETWEEN ONSET AND DEATH	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis (valvular) heart disease &amp; failure</u>							
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>  </u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>  </u>		19b. MAJOR FINDINGS OF OPERATION <u>  </u>				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>  </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/1</u> , 19 <u>55</u> , to <u>9/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/3</u> , 19 <u>55</u> , and that death occurred at <u>1 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Ernest N. Larson</u> M.D.				ADDRESS (Street, city, town, state) <u>Delmar, Del</u> DATE SIGNED <u>9/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hebron Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hebron, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Sept. 7, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u> ADDRESS <u>The Hill &amp; Johnson Co. Salisbury, Md.</u>			

# CERTIFICATE OF DEATH

9013

Reg. Dist. No.

Place of Birth

Age

Sex

Color

Marital Status

Occupation

Place of Death

Time of Death

Day of Death

Month of Death

Year of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of Burial Officer

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

BUREAU V. S.

SEP 2 1955

RECEIVED

Hebron, Maryland

Hebron Cemetery

9013

Hebron

The City of Baltimore, Maryland



9203

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Princess Ann, Rt #1, 191-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>P.O. Box 235</u>			
3. NAME OF DECEASED: (First) <u>Edith</u> (Middle) <u>L.</u> (Last) <u>Wilson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>September 20 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		8. DATE OF BIRTH: <u>Feb. 10, 1882</u>		9. AGE last birthday <u>73</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Leonard Marlon</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Wetzel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs Robert Buller, Princess Anne</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>1 Day</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-19</u> , 1955, to <u>9-20</u> , 1955, that I last saw the deceased alive on <u>9-19</u> , 1955, and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>		M.D. <u>Salisbury, Md.</u>		DATE SIGNED <u>9-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>9-22-55</u>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt Vernon, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-21-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holleray</u>		24. FUNERAL DIRECTOR <u>James Henman</u>		ADDRESS <u>Princess Anne, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 23 1955

RECEIVED